



The legacy of voluntarism: Charitable funding in the early NHS

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Abstract

Before 1948, approximately one-third of the United Kingdom (UK)'s hospital beds were located in voluntary hospitals, many of which continued to benefit from the funds generated by their historic endowments. When the National Health Service (NHS) was created, the vast majority of these hospitals were taken over by the State. This paper examines the neglected question of what happened to these endowments and the role which charity continued to play in the funding of NHS hospitals more generally. It makes an explicit attempt to examine the development of hospital services in each of the UK's constituent nations and shows how the treatment of endowments and the role of charity differed between them. It also highlights the continuing importance of arguments over the 'boundaries' between 'essential' and 'non-essential' forms of health service expenditure, and between the roles of the statutory and voluntary sectors more generally.

KEYWORDS

charity, health, hospitals, National Health Service, United Kingdom

In 1946, the Minister of Health for England and Wales, Aneurin Bevan, argued that the establishment of the new National Health Service (NHS) would liberate healthcare from the 'caprice of private charity'. He also argued that it was 'repugnant to a civilised community for hospitals to have to rely upon private charity' and sought to impose clear limits on the role which charity

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might play.¹ However, both inherited endowments and new gifts and donations continued to play a small but significant part in the financing of statutory health services. These funds were supposed to be used to support the provision of amenities for patients and staff and for research but could also be used more widely.

Despite this, the role of charity received very little attention from some of the earliest historians of the NHS, such as Ross, Eckstein, and Willcocks, although Dodd addressed the issue in a report for the British Hospitals Contributory Schemes Association in 1960.² It also received limited attention from Watkin, Pater, Honigsbaum, Rivett, Webster, Ham, and Klein,³ and only passing references in Brotherston et al. and McCrae's histories of Scottish healthcare.⁴ It received rather more attention from Prochaska, in his history of the King's Fund, but his account was largely confined to the provision of healthcare in England and Wales, and it was also addressed by Mohan and Gorsky, although their work focused more closely on the role played by voluntarism before 1939 and after 1980.⁵ Gray provided a fuller account of issues associated with the treatment of hospital endowments in her history of the Northern Ireland Hospitals Authority (NIHA).⁶ During the 1990s, the Directory of Social Change published a series of more polemical accounts and Meakin provided a painstaking legal discussion, but these works also had a more recent focus.⁷

The issue of charitable funding in the NHS has also received relatively little attention from historians of philanthropy. Prochaska said very little on the topic in either *The voluntary impulse* or in his contribution to the *Cambridge Social History of Modern Britain*, although he did highlight the introduction of restrictions on hospital fundraising in *Christianity and social service*.⁸ Trevelyan described the role played by voluntary service in the first 3–4 years of the NHS, and Owen provided a brief account of some of the differences in the treatment of teaching and non-teaching hospitals.⁹ Finlayson noted that 'Bevan's proposals were laced with a considerable number of concessions to the voluntary hospitals such as ... the protection of hospital endowments'.¹⁰ However, neither Owen nor Finlayson made any reference to the Hospital Endowments Fund (HEF) and, although Owen acknowledged the persistence of other kinds of 'free money', neither he nor Finlayson referred to the development of different arrangements outside England and Wales.¹¹

The role of charity during the first 30 years of the NHS has received renewed attention more recently. Ramsden and Cresswell explored the contribution made by voluntary organizations to

¹ *Hansard* (Commons), 5th series, vol. 422, 30 April 1946, cols. 46–7.

² Ross, *The National Health Service*; Eckstein, *The English health service*; Willcocks, *The creation of the National Health Service*; Dodd, *Hospitals and health services*, esp. pp. 24–31, 97–102. Gorsky has also drawn attention to the neglect of 'voluntarism' in NHS historiography more generally (Gorsky, 'Voluntarism', pp. 52–3).

³ Watkin, *The National Health Service*; Pater, *The making of the National Health Service*; Honigsbaum, *Health, happiness and security*; Rivett, *From cradle to grave*; Webster, *Problems of health care*; idem, *Government and health care*; idem, *National Health Service*; Klein, *New politics of the NHS*; Ham, *Health policy*.

⁴ Brotherston et al., *Improving the common weal*; McCrae *The National Health Service in Scotland*.

⁵ Prochaska, *Philanthropy and the hospitals of London*; Mohan and Gorsky, *Don't look back?*

⁶ Gray, 'Government and the administration of hospital services'.

⁷ Fitzherbert, *Charity and the National Health*; Lattimer and Holly, *Charity and NHS reform*; Lattimer, Holly and Kovats, *The gift of health*; Meakin, *Charity in the NHS*.

⁸ Prochaska, *The voluntary impulse*; idem, 'Philanthropy'; idem, *Christianity and social service*, p. 153.

⁹ Owen, *English philanthropy*, p. 545.

¹⁰ Finlayson, *Citizen, state and social welfare*, p. 272.

¹¹ Philanthropy's contribution to healthcare finance has also been acknowledged briefly by a former Head of Policy at the UK's Charities Aid Foundation, Rhodri Davies. See Davies, *What is philanthropy for?*, p. 75.



the development of first-aid services; Piggott discussed the role played by religious communities in the preservation of 'Hospital Sunday'; and Millward examined the roles played by Leagues of Friends in the west Midlands.¹² However, none of these papers looked at the contribution of charitable funding more broadly. Other writers have focused on more recent developments. Stewart et al. examined the rise of crowdfunding during the coronavirus disease 2019 (COVID-19) pandemic and Stewart and Dodworth explored a range of fundraising practices in contemporary Scotland.¹³ Bowles et al. surveyed the contribution of charity to the income of contemporary NHS Trusts in England and Abnett, Bowles, and Mohan discussed the different ways in which these funds have been used.¹⁴ However, all of these papers are primarily concerned with the present day.

This paper adopts a different approach by examining the contribution made by prewar endowments and subsequent gifts to the financing of hospital services during the NHS's first quarter-century. It looks at what happened to the distribution of the voluntary hospitals' existing endowments after 1948 and integrates this into the broader history of non-Exchequer health service funding. In contrast to much work on the history of the 'British' NHS, it takes an explicitly 'four-nations' approach to developments across the whole of the UK. It demonstrates that charity continued to play a small but significant role in the mixed economy of healthcare after 1948 and highlights the questions this raised about the distinctions between 'essential' and 'non-essential' forms of health expenditure and the boundary between voluntary and statutory responsibility.

The period between 1948 and the early 1970s marked a distinctive era in the history of healthcare in each of the UK's health services. It began with the establishment of the NHS in England and Wales, Scotland, and Northern Ireland on the 'appointed day' of 5 July 1948 and ended with a series of changes in the management of charitable funding and the organization of health services more generally.¹⁵ In England and Wales, both the HEF and the separate status of the majority of teaching hospitals were abolished following the reorganization of the NHS in 1974.¹⁶ In Scotland, a new body, the Scottish Hospitals Trust (SHT), was established to administer hospital endowments in 1971, and the health service itself was reorganized 3 years later.¹⁷ In Northern Ireland, Belfast's Mater Infirmorum Hospital became part of the statutory health service in 1971 and the NIHA was replaced by four health and personal social service boards in 1973.¹⁸

Although charitable finance makes only a small contribution to overall health spending, it has received more attention in recent years. In 2016, a charity fundraiser, Bevis Man, argued that NHS Trusts 'are now more in need of NHS charities to contribute towards major redevelopment

¹² Ramsden and Cresswell, 'First aid and voluntarism'; Piggott, 'Hospital Sunday'; Millward, 'Its many workers and subscribers'.

¹³ Stewart, Nonhebel, Möller, and Bassett, 'Doing "our bit"'; Stewart and Dodworth, 'The biggest charity you've never heard of'.

¹⁴ Bowles, Clifford, and Mohan, 'The role of charity in a public health service'; Abnett, Bowles, and Mohan, 'The role of charitable funding'.

¹⁵ The three founding acts were the [National Health Service Act, 1946](#) (9 & 10 Geo. 6 C. 81); the [National Health Service \(Scotland\) Act, 1947](#) (10 & 11 Geo. 6 C. 27); and the [Health Services Act \(Northern Ireland\), 1948](#) (Acts of the Northern Ireland Parliament, 1948 C. 3).

¹⁶ [NHS Reorganisation Act 1973](#), sects. 14–15, 23.

¹⁷ [Hospital Endowments \(Scotland\) Act, 1971](#); [NHS Reorganisation Act](#).

¹⁸ The Mater Infirmorum Hospital was one of Belfast's largest voluntary hospitals before 1948 and remained outside the statutory health service when the 1948 Act came into operation. See Gray, 'Government and the administration of hospital services', p. 356 and Chronology; and Martin, 'Why have a Catholic hospital at all?'

**TABLE 1** Voluntary and public hospitals in England and Wales, Scotland, and Northern Ireland, 1934–48.

	Period	Average annual population (000s)	Voluntary hospitals		Public hospitals		Total	
			Hospitals	Beds	Hospitals	Beds	Hospitals	Beds
England and Wales	1938	41 215	1255	87 235	1882	175 868	3137	263 103
Scotland	1934	4934	206	12 575	243	18 679	449	31 254
Northern Ireland	1938–48	1331	22	2512	40	10 948	62	13 460
Total	1934–48	47 480	1483	102 322	2165	205 495	3648	307 817

Note: The Northern Ireland Hospitals Authority (NIHA) listed the hospitals for which it assumed responsibility in 1948. This list has been compared with the list of voluntary hospitals in the Voluntary Hospitals Database. The Mater Infirmorum Hospital was a voluntary hospital which chose to remain independent until 1971. It accommodated 318 beds in 1938. *Sources:* Population: Mitchell, *British historical statistics*, pp. 13–14; Hospital statistics: England and Wales: Pinker, *English hospital statistics*, p. 61; Scotland: Department of Health for Scotland (DHS), *Report of the Committee on Scottish Health Services*, App. IV; Northern Ireland: NIHA, *First Annual Report*, pp. 75–6; see also Gray, ‘Government and the administration of hospital services’, pp. 412, 524–5; and Voluntary Hospitals Database.

of wards and units¹⁹ and the influential think tank, New Philanthropy Capital, claimed that ‘charities ... have a legitimate role to play in the transformation of the NHS and the wider health care system’.²⁰ During the early months of the COVID-19 pandemic, Captain Tom Moore raised over £30 M for NHS Charities Together, and the organization enjoyed an annual income of approximately £150 M.²¹

To understand the role of charity before the early 1970s, this paper begins by describing the distribution of hospital endowments before the NHS was created. It then examines the ways in which hospital endowments were treated in the three Health Service Acts and the impact of this legislation on the distribution of endowment income in England and Wales, Scotland, and Northern Ireland. Section III discusses the role played by endowments and other ‘free moneys’ in the financing of hospital services and section IV examines the ways in which these moneys were spent. Section V explores the implications of this discussion for our understanding of the history of health policy in each of the UK’s territories and the role of charity today.

I | VOLUNTARY HOSPITALS BEFORE 1948

Prior to 1948, the UK had a medley of different types of hospitals. The oldest institutions were the voluntary hospitals. The earliest had been founded in the twelfth century but the majority dated from the eighteenth and nineteenth centuries. Although they had been founded as charitable institutions, they derived an increasing proportion of their income from public authorities and investments and, from the 1860s, they also received funds from paying patients and hospital insurance funds.²² During the 1930s and 1940s, these institutions accommodated almost one-third of all the UK’s hospital beds (see table 1). They were joined by various types of public-sector

¹⁹ Man, ‘NHS charities’.

²⁰ Bull *et al.*, *Untapped potential*, p. 16.

²¹ NHS Charities Together, *Annual Report 2020*, p. 1.

²² Harris, *Origins of the British welfare state*, pp. 95–6, 227–31.

**TABLE 2** Voluntary hospitals in England and Wales, Scotland, and Northern Ireland, 1938.

		England and Wales	Scotland	Northern Ireland	United Kingdom
Number of hospitals		890	122	24	1036
Beds per hospital					
Not stated/zero		120	7	10	137
Stated	Minimum	5	7	21	5
	Maximum	885	1139	538	1139
	Mean	90.33	110.40	124	92.75
	SD	109.34	185.98	143.55	119.18
Investment income per bed (£)	n/a	120	7	10	137
	0	586	40	10	636
	0 < £ ≤ 10	40	57	0	97
	10 < £ ≤ 20	66	2	2	70
	20 < £ ≤ 30	42	3	2	47
	30 < £ ≤ 40	22	7	0	29
	40 < £ ≤ 50	7	1	0	8
	50 < £ ≤ 60	0	4	0	4
	60 < £ ≤ 70	2	1	0	3
	70 < £ ≤ 100	3	0	0	3
	≥100	2	0	0	2

Source: Mohan and Gorsky, *Voluntary Hospitals Database*.

hospital, including poor law hospitals, 'lunatic' asylums, maternity hospitals, and from the 1870s, municipally financed hospitals for patients with tuberculosis and other infectious diseases.

The interwar years witnessed significant changes in the funding of voluntary hospitals.²³ Although charity remained an important part of hospital finance,²⁴ hospitals became less reliant on subscriptions and donations and more reliant on the income generated by hospital contributory schemes. However, many of these hospitals also derived considerable benefit from the income generated by their endowments. In 1938, investment income accounted for approximately 11 per cent of total voluntary hospital income but this money was not distributed evenly. The majority of hospitals derived no income at all from endowments and other investments whilst a minority derived substantial amounts. This was especially true of some of London's voluntary hospitals, including Guy's (26.5 per cent), St Thomas's (37 per cent), and St Bartholomew's (53.4 per cent).²⁵

There were also significant differences in the spread of investment income across the different parts of the UK (table 2).²⁶ More than 80 per cent of the voluntary hospitals in England and Wales, Scotland, and Northern Ireland reported annual incomes of less than £10 per bed from their endowments and investments in 1938. However, seven institutions received between £50 and £70 per bed and five institutions received more than £70 per bed. These institutions – St

²³ Gorsky et al., 'The financial health of voluntary hospitals'.

²⁴ Hayes and Doyle, 'Eggs, rags and whist drives', pp. 718–9.

²⁵ Mohan and Gorsky, 'Voluntary hospitals database'. See also Eckstein, *The English health service*, p. 75.

²⁶ See also Mohan, "'The caprice of charity'".



Bartholomew's, St Thomas's, Guy's, the London Hospital, and the Great Ormond Street Hospital for Sick Children – were all London based.

These endowments played an important role in debates over the establishment of the NHS.²⁷ In 1941, when Ernest Brown outlined his initial plans for the creation of a National Hospital Service, he expected the voluntary hospitals to retain their independent status, and this position was reiterated in both the Brown Plan of 1943 and the 1944 Health Service White Paper.²⁸ However, the Labour Party wanted the State to take responsibility for the core funding of all hospital services and this raised fundamental questions about the position of voluntary hospitals and their endowments.²⁹ After accepting that the English and Welsh teaching hospitals (though not the Scottish teaching hospitals) should retain their endowments, the new government argued that the endowments of the remaining hospitals should be pooled in the interests of both equity and efficiency.³⁰ By contrast, the Conservatives complained that the 'confiscation' of endowments disrespected the wishes of previous donors, undermined the connections between hospitals and their localities, and discouraged future donations.³¹

Despite these arguments, both the NHS Act and the NHS (Scotland) Act passed with large majorities.³² The first act confirmed that the English and Welsh teaching hospitals would retain control of their existing endowments, whilst the endowments of the remaining hospitals would be pooled under a new HEF.³³ In Scotland, decisions on the distribution of endowment income were delegated to a Hospital Endowments Commission (HEC), which meant that no further decisions were taken until the mid-1950s.³⁴

The 1946 Act also stipulated that 'any moneys forming part of the HEF may be ... paid over to the National Debt Commissioners and by them invested in any securities which are ... authorised by Parliament as investments for savings bank funds'.³⁵ This was intended to ensure that the funds were invested securely, but it also meant that they secured relatively low rates of return. This helps to explain why the real value of the HEF declined over time, even though the value of the funds invested by teaching hospitals increased, and this led to the relaxation of investment restrictions under the Health Services and Public Health Act of 1968.³⁶

Although Bevan thought it was 'repugnant' for hospitals to have to rely on charity, hospitals retained the right to receive future gifts and donations. Section 7 (4) of the 1946 Act stated that endowments given between the passage of the Act and the 'appointed day' should remain with the Management Committee of the hospital to which the endowment was given, and section 7

²⁷ Prochaska, *Philanthropy and the hospitals of London*, pp. 159–61.

²⁸ *Hansard* (Commons), 5th series, vol. 374, cols. 1116–20; TNA MH80/25 (NHS Bill: Preliminary Papers); Ministry of Health and Department of Health for Scotland, *A National Health Service* (p. 21); see also Willcocks, *The creation of the National Health Service*, pp. 24–9; Webster, *Problems of health care*, pp. 31–4, 44–57.

²⁹ Webster, *Problems of health care*, p. 82.

³⁰ See, for example, *Hansard* (Commons), 5th series, vol. 425, 22 July 1946, cols. 1793–5. For Scotland, see McCrae, *The National Health Service in Scotland*, p. 227. Eckstein (*the English National Health Service*, p. 337) claimed that Scottish teaching hospitals 'form[ed] such a large part of the country's hospital resources that no regional service of any value could have been organised [without them]'.

³¹ See, for example, *Hansard* (Commons), 5th series, vol. 425, 22 July 1946, cols. 1802–4.

³² Webster, *Problems of health care*, pp. 94–107.

³³ NHS Act, 1946, section 7.

³⁴ NHS (Scotland) Act, 1947, sections 7–8.

³⁵ NHS Act, 1946, section 56 (2).

³⁶ See, for example, TNA MH15/7, DHSS, 'HEF: Investment Policy' (September 1969).



(1) of the 1947 Act introduced a similar clause for Scotland. The acts also made further provision for donations received after they came into operation. Sections 59 and 60 of the 1946 Act allowed Regional Hospital Boards (RHBs) and the Boards of Governors (BGs) of Teaching Hospitals ‘to accept, hold and administer property upon trust for purposes relating to hospital services or ... research’, and to continue to receive both capital and income from these trusts. Sections 58 and 59 of the 1947 Act conferred similar powers on RHBs and Boards of Management in Scotland. As a Ministry of Health memorandum explained, ‘it is therefore open to members of the public, independent contributory schemes and other organisations to give regular or special sums for either general or special hospital purposes, and to testators similarly to bequeath money to Boards or Committees’.³⁷

In Northern Ireland, health policy was a devolved responsibility of the Northern Ireland Parliament. The Minister of Health, William Grant, wanted to allow Northern Ireland’s voluntary hospitals to retain their endowments, but the Treasury argued that this would constitute a ‘departure from parity’.³⁸ It was therefore agreed that control of the endowments would pass to the province’s newly formed Hospital Management Committees (HMCs). The Health Services Act (Northern Ireland) established 29 such committees, of which 18 were responsible for more than one hospital.³⁹ However, HMCs were also required to ensure that endowments were only used for the benefit of the hospitals for which they were originally intended.⁴⁰ As the Tanner Committee explained, there was ‘no provision in Northern Ireland for the pooling or redistribution even of general endowments among hospitals and control of the funds remaining after the discharge of ... liabilities rests in many instances with individual hospitals, not their Management Committees’.⁴¹

II | THE DISTRIBUTION OF HOSPITAL ENDOWMENTS

As the previous section has shown, the 1946 Act established different arrangements for the treatment of endowments held by teaching and non-teaching hospitals. Any endowments held by a teaching hospital, or by a hospital which formed part of a teaching hospital group, were transferred to the hospital’s Board of Governors, whereas endowments held by non-teaching hospitals were transferred to the HEF. Although the Act provided some scope for endowments to be shared within teaching hospital groups and between non-teaching hospitals, it did little to redistribute these resources between teaching hospital groups or between teaching and non-teaching hospitals. This meant that the fundamental distinction between teaching and non-teaching hospitals remained intact.

Although the Government’s appropriation of hospital endowments attracted considerable controversy, the exemption of the English and Welsh teaching hospitals provoked little debate. In April 1946, Bevan told the House of Commons that ‘the teaching hospitals will be left with all their liquid endowments and more power ... than in the past’, and on 22 July he said that ‘the endowments of teaching hospitals are distinguished, to a very large extent, from the endowments of

³⁷ TNA MH99/37, ‘Endowment and other “free” money’ (HMC (48) 25; BG (48) 23)), para 4.

³⁸ Gray, ‘Government and the administration of hospital services’, pp. 127–35. The politics associated with the process of health service reform in Northern Ireland have also been discussed by [Privilege](#), ‘The Northern Ireland Government and the welfare state’; and [Privilege and Jones](#), ‘Government, local government and health reform in Northern Ireland’.

³⁹ Gray, ‘Government and the administration of hospital services’, pp. 527–33.

⁴⁰ NIHA, *Second Annual Report*, p. 92.

⁴¹ [Government of Northern Ireland](#), *Report ... on the Health Services of Northern Ireland*, paras. 124–6.



general hospitals because ... [they] are earmarked for special purposes, such as cancer research'.⁴² In 1969, a Treasury review attributed the separate treatment of teaching hospitals to '[their] exceptional standing ... their eminent suitability as centres for research and innovation, and their need for special status and sufficient independence as institutions working in close association with the Universities'.⁴³

In 1948, the Government announced plans for the creation of 36 teaching hospital groups, including approximately 150 separate institutions and 27 000 hospital beds.⁴⁴ These institutions accounted for approximately 5 per cent of the total number of hospitals in England and Wales and 10 per cent of the total number of beds (see table 1), and their endowments had a combined value of approximately £20 million.⁴⁵ This was roughly equivalent to the net value of the assets transferred to the HEF.⁴⁶ The income from these assets was then shared between the non-teaching hospitals, including approximately 2800 individual hospitals and more than 200 000 hospital beds.⁴⁷

In contrast to the 1946 Act, the NHS (Scotland) Act included an explicit commitment to the transfer 'in appropriate circumstances' of endowments between both Boards of Management and RHBs,⁴⁸ and this was reflected in the HEC's recommendations. Although some argued that Scottish teaching hospitals should be treated on a similar basis to teaching hospitals in England and Wales,⁴⁹ the HEC concluded that the majority of the funds should be shared within (though not between) the country's five RHBs.⁵⁰ The Commission also recognized that, even though 'the bulk of research work has been carried out in teaching hospitals ... many other hospitals have made and can make significant contributions', and recommended the establishment of a new body, the Scottish Hospital Endowments Research Trust (SHERT), to facilitate this. This work was to be funded by contributions from all the RHBs, with the exception of the Northern Board, whose endowment income was more limited.⁵¹

Tables 3 and 4 illustrate the impact of these decisions on the distribution of endowment income both within and between Scotland's RHBs. Table 3 compares the average value of the income generated by hospital endowments in each of the five regions and table 4 presents how income was redistributed within the south-eastern region, which was also the wealthiest. This table presents how the gap between the poorest and wealthiest institutions was reduced and how the mechanism

⁴² *Hansard* (Commons), 5th series, vol. 422, col. 63 (30 April 1946); *idem.*, vol. 425, cols. 1793–4 (22 July 1946).

⁴³ [TNA T227/4008](#) ('Hospital Service Trust Funds', 22/7/69, para. 13).

⁴⁴ Webster, *Problems of health care*, p. 270.

⁴⁵ There are conflicting estimates of the total value of the teaching hospitals' endowments. Bevan suggested that they had a total value of approximately £13 M (*Hansard* (Commons), 5th series, vol. 422, 1 May 1946, col. 304), but Lord Moran thought they were worth £18 M (*Hansard* (Lords), 5th series, vol. 140, 16 April 1946, col. 829). The Treasury subsequently proposed a figure of £20 M ([TNA T227/888](#) (HEF Briefing Paper, 20/3/50, para. 9)).

⁴⁶ HEF, *Account 1948–9*, para. 3.

⁴⁷ A small number of institutions declined to join the NHS and were 'disclaimed'. Steph Haydon and John Mohan (personal communication) have identified 297 such institutions across the whole of England and Wales, of which approximately half can be identified as hospitals (as opposed to various types of care home, specialist clinics, or open-air schools).

⁴⁸ NHS (Scotland) Act, 1947, section 8 (2).

⁴⁹ See, for example, *Hansard* (Lords), 5th series, vol. 147, cols. 311–13 (1 May 1947); *idem.*, cols. 591–2 (12/5/47); and the following memoranda held by the National Records of Scotland ([NRS HH96/2](#)): HEC 49 (8), 'Board of Management for Edinburgh Central Hospitals to the Secretary, HEC, 11/2/50'; and HEC 49 (9), 'Board of Management for Glasgow Royal Infirmary and Associated Hospitals to HEC, 30/1/50'.

⁵⁰ DHS, *Hospital endowments*, para. 8.

⁵¹ DHS, *Proposals for a Scottish Medical Research Fund*, para. 8; *idem.*, *Hospital endowments*, paras. 8, 20–1.

**TABLE 3** Distribution of endowment income between Scotland's RHBs, 1955.

Region	No. of beds at preparation of scheme	Income at preparation of scheme (£)	Amount per bed	Final income (£)	Amount per bed
Northern	2268	8084	3.56	7591	3.35
North-eastern	5628	52 025	9.24	41 453	7.37
Eastern	7096	55 503	7.82	43 489	6.13
South-eastern	13 211	150 963	11.43	109 660	8.30
Western	36 808	209 313	5.69	167 353	4.55
All	65 181	475 888	7.30	369 546	5.67

Note: The table presents the value of the income generated per bed after subtracting contributions to central administrative costs and the research fund. *Source:* DHS, *Hospital endowments*, pp. 114–28.

TABLE 4 Distribution of endowment income within the South-eastern RHB, 1955.

Hospital	No. of beds at preparation of scheme	Income at preparation of scheme (£)	Amount per bed (£)	Final income (£)	Amount per bed (£)
Royal Infirmary of Edinburgh & Associated Hospitals	1452	47 470	32.69	27 260	18.77
Edinburgh Central Hospitals	515	15 240	29.59	6785	13.17
Edinburgh Southern Hospitals	460	16 600	36.09	6975	15.16
Astley Ainslie, Edenhall & Associated Hospitals	470	36 900	78.51	23 000	48.94
West Fife Hospitals	580	6030	10.40	4930	8.50
East Fife Hospitals	553	12 000	21.70	6560	11.86
Edinburgh Northern Hospitals	961	10 077	10.49	10 077	10.49
East Lothian Hospitals	561	2524	4.50	2524	4.50
Scottish Borders Hospitals	650	3762	5.79	3762	5.79
Edinburgh Royal Victoria & Associated Hospitals	830	360	0.43	2030	2.45
Royal Edinburgh Hospital for Mental and Nervous Disorders	1148	0	0.00	2900	2.53
Fife Mental Hospitals	1115	0	0.00	2800	2.51
West Lothian (Bangour) Hospitals	2200	0	0.00	5600	2.55
Gogarburn Mental Deficiency Institution	661	0	0.00	1650	2.50
Rosslynlee & Haddington Mental Hospitals	637	0	0.00	1752	2.75
Dingleton Mental Hospital	418	0	0.00	1055	2.52
Total (Hospitals only)	13 211	150 963	11.43	109 660	8.30

Note: The Astley Ainslie, Edenhall and Associated Hospitals were a specialist group of hospitals supported by a bequest from David Ainslie. The Commission decided to treat them as a special case in recognition of their particular focus on convalescence and rehabilitation. It agreed to set aside sufficient funds to generate an annual income of £17 700 for development purposes and £5300 for ordinary purposes. For further details, see DHS, *Hospital Endowments*, para. 29. *Sources:* See table 3.



ensured that some funds were made available to all hospitals. However, it also highlights the extent to which funds continued to be concentrated in certain institutions, whilst others, including the region's psychiatric hospitals, remained neglected.

We can also use these data to compare the value of the income generated by endowments in Scotland with the income generated in England and Wales. In England and Wales, the HEF sought to ensure that each non-teaching hospital would receive an annual income of 18 shillings (s) (£0.90) per bed in 1948/9.⁵² This figure had increased to 30s (£1.50) per bed by 1955.⁵³ In Scotland, the average value of the payments generated by the redistribution of endowment incomes ensured that all of Scotland's hospitals received an income of at least £2.14 per bed, and the average value of the payments made to hospitals which had previously received no endowment income was just under 50s (£2.49).⁵⁴

During the 1960s, the formula used to allocate endowment income by both the HEF and the HEC was criticized on two counts. The original allocations were based on the number of beds in each hospital in the early years of the NHS and took no account of subsequent changes.⁵⁵ The formula also took no account of the needs of different types of patient.⁵⁶ This was particularly relevant to the provision of comforts and amenities for 'geriatric, chronic sick, mentally-ill and mentally-subnormal patients' requiring long-term care.⁵⁷ As a result, the Department of Health and Social Security (DHSS) and the Scottish Home and Health Department (SHHD) made two adjustments to the allocation formula at the end of the decade. It was agreed that future allocations should be based on the number of beds at the end of the preceding year and that long-stay beds should be 'double-weighted' for funding purposes.⁵⁸

III | 'FREE MONEY'

The 1946 Act said that any endowments held by non-teaching hospitals before the Act was passed should be transferred to the HEF, whereas any endowments received after that date would remain with the hospitals that received them (see section I). We can identify the income generated for these hospitals by their pre-1946 endowments in the NHS accounts. It is not possible to isolate the income which the teaching hospitals and their groups obtained from pre-1946 endowments because these funds were retained by Boards of Governors and the summarized accounts do not distinguish the income obtained from 'old' endowments from that generated by new ones.

⁵² HEF, *Account 1948-9*, para. 3.

⁵³ DHS, *Hospital endowments*, para. 3.

⁵⁴ Ibid. In 1969, a DHSS official noted that, whereas the HEF aimed to distribute 33s (£1.65) per bed in England and Wales, Scottish officials were proposing to distribute £3 per bed. He attributed this to the inclusion of teaching hospitals in the Scottish proposal (TNA MH170/102, Bourton to Perry, 24/12/69).

⁵⁵ See, for example, TNA MH137/12 (J. Allan, 'The Hospital Endowments Fund', 21/8/62, para. 6; and Lowrie (SHHD) to Paget (Ministry of Health), 5/4/63).

⁵⁶ See, for example, TNA MH170/102 (Bourton to Taylor, 28/7/69).

⁵⁷ TNA MH170/102, 'DHSS Press Service, 'Hospital Endowments Fund', 15/10/69. The needs of such patients had recently been highlighted by Geoffrey Howe's report into the maltreatment of patients at Ely Psychiatric Hospital in Cardiff. The relevance of the 'post-Ely climate' was highlighted by C.G. Taylor on 27/7/69 (see TNA MH170/102, Taylor to Bourton et al., 27/7/69, para. 6).

⁵⁸ SI 1969 no. 1525: NHS (HEF – Distribution of Income) Regulations, 1969; SHHD, *Hospital endowments*, p. 2.

**TABLE 5** Income generated from the HEF, 1950–74.

Year	Income from HEF (£000)	Year	Income from HEF (£000)
1950/51	944	1962/63	707
1951/52	800	1963/64	707
1952/53	881	1964/65	718
1953/54	670	1965/66	742
1954/55	713	1966/67	739
1955/56	714	1967/68	786
1956/57	712	1968/69	782
1957/58	719	1969/70	769
1958/59	718	1970/71	766
1959/60	662	1971/72	767
1960/61	698	1972/73	765
1961/62	698	1973/74	907

Source: Summarized accounts of RHBs, Boards of Governors of Teaching Hospitals, HMCs, and Executive Councils, 1948/9–73/4.

The HEF generated approximately £700 000 for the benefit of RHBs and HMCS per year between 1950/1 and 1973/4 (table 5). However, the value of these payments was eroded by inflation and there was growing concern about the declining market value of the fund itself. The fund's managers were only permitted to invest in a limited range of stocks and this meant that its market value fell from just over £20 M in 1948/9 to £9.7 M 20 years later.⁵⁹ In 1968, the government relaxed the restrictions on investment policy and the market value increased to £12.7 M in 1971/2, before declining to £10.6 M in the following year.⁶⁰

Although hospitals were still able to benefit from charitable donations, the government was anxious to avoid any implication that the money provided by the Exchequer was insufficient for their 'normal needs'.⁶¹ Consequently, although the Ministry continued to encourage fundraising by independent organizations, such as Hospital Leagues of Friends and the organizers of Hospital Sunday appeals,⁶² it said that no fundraising activities should take place on hospital grounds and prohibited the display of collection boxes for named hospitals in railway stations and public houses.⁶³ It also insisted that hospital staff could only take part in fundraising activities when out of uniform and banned members and officers of hospital boards and committees from taking part altogether.⁶⁴ However, these restrictions were relaxed after the Conservatives returned to power. In 1952, it was agreed that the members of hospital authorities – but not their officers – could engage in fundraising activities in a private capacity,⁶⁵ and nurses were allowed to take part in independently organized fundraising activities whilst wearing their uniforms from 1953

⁵⁹ TNA MH115/7, DHSS, 'HEF Investment Policy', September 1969; see also T227/4008, 'NHS reorganisation: the future of the HEF'; and HEF, *Annual Accounts*, 1948/9–73/4.

⁶⁰ The rules governing investments were relaxed under section 7 (2) of the *Health Services and Public Health Act*, 1968 (1968 C. 46). For the market value of the HEF in subsequent years, see HEF, *Annual accounts*, 1969/70–1973/4.

⁶¹ TNA MH99/37, 'NHS: Appeals for funds, etc.', para. 2 (18/12/48) (RHB (48) 41A; HMC (48) 25A; BG (48) 23A).

⁶² Dodd, *Hospitals and health services*, pp. 24–5; Millward, 'Its many workers and subscribers'; Piggott, 'Hospital Sunday'.

⁶³ TNA MH99/37, 'NHS: Appeals for funds, etc.', para. 3 (18/12/48) (RHB (48) 41A; HMC (48) 25A; BG (48) 23A).

⁶⁴ *Ibid.*

⁶⁵ TNA MH99/37, Ministry of Health, 'Voluntary organisations in hospitals and appeals for funds', 14/2/52.

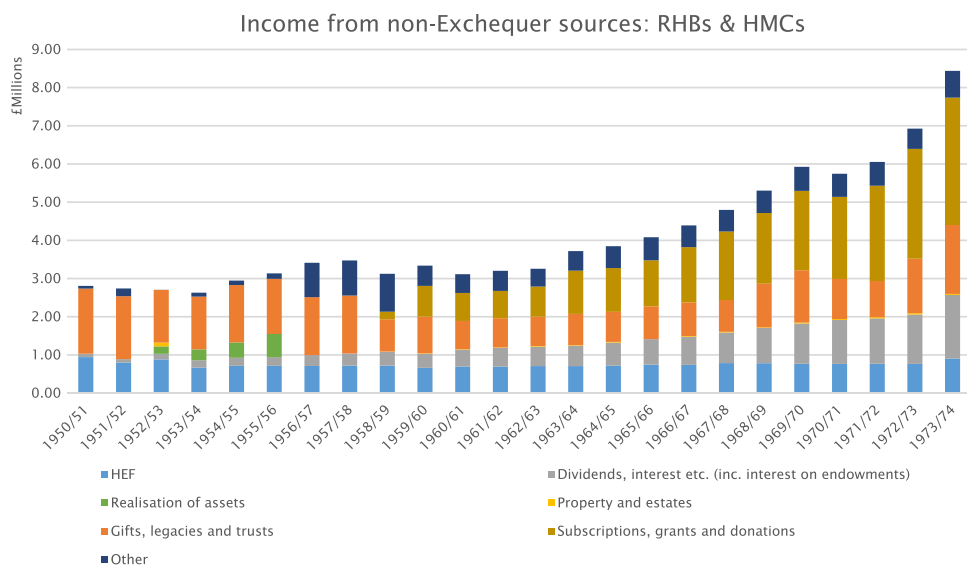


FIGURE 1 Income from non-Exchequer sources: regional hospital boards (RHBs) & hospital management committees (HMCs). *Source:* Summarized accounts of RHBs, Boards of Governors of Teaching Hospitals, HMCs and Executive Councils, 1948/9–73/4. [Colour figure can be viewed at wileyonlinelibrary.com]

onwards.⁶⁶ The Minister of Health, Iain MacLeod, announced that contributions to capital expenditure from non-Exchequer funds would no longer be offset against capital allocations to hospital boards in 1954,⁶⁷ and Ministry of Health officials endorsed the use of hospital grounds for fundraising purposes in 1959.⁶⁸ As we can see from figure 1, RHBs and HMCs continued to receive income from new gifts, legacies and donations throughout the period, but they also generated a separate income strand from subscriptions, grants, and donations from 1958. The combined value of the sums generated under these headings rose to more than 60 per cent of the total value of ‘free’ or non-Exchequer funds by the end of the period.

Although the post-war Labour government was anxious to distance hospital authorities from any direct involvement in fundraising activities, gifts, legacies and trusts were already an established part of the NHS before Labour left office in 1951, and income from subscriptions, grants, and donations increased in both absolute and real terms after the party regained power in 1964.⁶⁹ The potential value of this income was also acknowledged by officials and Ministers during Labour’s period of office. In 1967, a Government official warned against proposals to abolish the HEF on the grounds that ‘this might discourage present-day donors and ... [generate] a net loss of income which the Exchequer would be pressed to make good’.⁷⁰ In 1969, the Secretary of State for Health

⁶⁶ TNA MH99/37, ‘NHS: Appeals for funds, etc.’, 13/6/53 (RHB (53) 63; HMC (53) 59; RG(53) 61).

⁶⁷ Prochaska, *Philanthropy and the hospitals of London*, p. 184.

⁶⁸ TNA MH99/37, Hewitt (Ministry of Health) to Williams (Welsh Board of Health), 9/11/59.

⁶⁹ The combined value of the income generated from gifts, legacies, trusts, subscriptions, grants, and donations increased by 43% in real terms (using a price index calculated by the Royal Commission on the NHS in 1979) between 1963/4 and 1969/70 (*Royal Commission on the NHS, Report*, table E8).

⁷⁰ TNA T227/4008, Anson to Rampton, 24/1/67.



and Social Security, Richard Crossman, asked ‘whether it would be desirable positively to encourage future donations and legacies to NHS authorities ... and ... whether some new and special tax concessions should be offered in respect of such donations and legacies’.⁷¹ Although no new concessions were introduced, Crossman rejected plans to pool endowment funds to ensure that the flow of donations was maintained.⁷² In 1970, the government said that ‘area health authorities will be able to accept and seek fresh gifts in aid of any part of their work, as happens at present. It is hoped that the public of each locality will continue to give generous support to their local health services’.⁷³

The decision to allow teaching hospitals to retain their original endowments means it is not possible to distinguish the income generated from pre-1946 endowments from the income generated from subsequent endowments. However, if we compare the combined value of the income received by non-teaching hospitals from the HEF and their post-1946 endowments with the aggregate value of the income generated by teaching hospital endowments, there is little difference.⁷⁴ On the other hand, the market value of teaching hospital endowments does appear to have increased more rapidly. In 1969, a Treasury official estimated that the aggregate value of the endowments held by the HEF and individual RHBs and HMCs was between £27 M and £36 M, whereas the market value of the endowments held by Boards of Governors was approximately £43 M.⁷⁵

Figure 2 also enables us to compare other aspects of the income generated by the different types of hospitals from non-Exchequer sources. The teaching hospitals derived substantially more income from property and estates, but they generated much smaller sums from ‘gifts, legacies, and trusts’ and ‘subscriptions, grants, and donations’. This may be because they were less likely to attract smaller gifts and donations, or because income from these sources was labelled differently.

Although the Comptroller and Auditor-General published annual data on the income generated from non-Exchequer sources for hospitals in England and Wales, there are no comparable Scottish data. However, annual accounts were published by the SHERT. The Trust achieved its goal of generating at least £100 000 from its investments in almost every year from 1957/8 to 1973/4, and this figure was supplemented by a small but increasing flow of donations, legacies, and covenants. However, there was also growing concern about the declining capital value of

⁷¹ TNA T227/4008, Widdop, ‘Hospital service trust funds’, 10/9/69.

⁷² TNA T227/4008, Maclean, 20/9/69.

⁷³ DHSS, *National Health Service*, para. 80. The Green Paper was published, with a foreword by Crossman, before Labour left office. The SHHD Working Party on Hospital Endowments also recommended that ‘financial support for the hospital service through donations and legacies ... should be encouraged’ (SHHD, *Hospital endowments*, para. 2). Although Mohan and Breeze (*Logic of charity*, p. 16) have argued that ‘governments since at least the Thatcher administrations (1979–92) have attempted to encourage an expansion of charitable giving to, and provision by, the charitable sector’, the evidence presented in this paragraph shows that support for such initiatives can be traced back much further.

⁷⁴ Over the period 1950/1–73/4, the aggregate value of the sums received by RHBs and HMCs from the HEF and other endowments was £32.4 M, and the aggregate value of the income generated by teaching hospital endowments was £32.3 M (see *Summarised accounts of Regional Hospital Boards, Boards of Governors of Teaching Hospitals, Hospital Management Committees and Executive Councils, 1948/9–1973/4*).

⁷⁵ The author suggested that the value of the sums held by RHBs and HMCs was £15.7 M. If this were added to the current value of the HEF (£11.6 M), the combined value would be £27.3 M. However, they also suggested that the total value of hospital endowment funds (including the HEF) was ‘of the order of £79 M, of which Boards of Governors enjoy about £43 M, or some 54.4 per cent’, which suggests that the value of the funds held by other bodies was somewhat higher. See TNA T227/4008, ‘Hospital Service Trust Funds’, 22/7/69, paras. 10, 17.

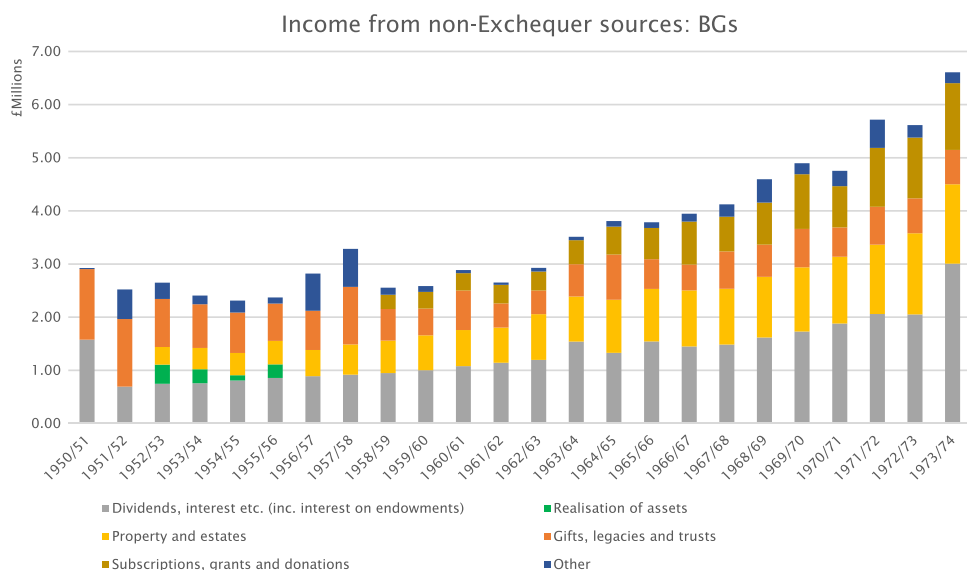


FIGURE 2 Income from non-Exchequer sources: BGs. *Source:* See figure 1. [Colour figure can be viewed at wileyonlinelibrary.com]

the Trust's investments,⁷⁶ and this was echoed more widely. In 1969, the SHHD Working Party concluded that the capital value of the investments held by Boards of Management, RHBS, and the SHERT had fallen by approximately 26 per cent between 1955 and 1967, and recommended the establishment of a central investment fund.⁷⁷ This resulted in the creation of a new central investment body, the SHT, in 1971.⁷⁸

The Health Services Act (Northern Ireland) described the funds which a hospital had accumulated before 5 July 1948 as 'endowments' and gifts, donations, and bequests received after the appointed day as 'gifts',⁷⁹ and the NIHA showed the combined value of the income generated from 'investments' and gifts from 1951/6 onwards. Investment income rose from an annual average of just under £60 000 in the early-1950s to approximately £100 000 during the 1960s and more than £150 000 (at current prices) in the early 1970s (see figure 3). The annual value of the gifts received following the appointed day ranged from £45 000–80 000 during the 1950s and from £50 000 to more than £145 000 during the 1960s, before rising again during the early 1970s.

These figures do not provide a full account of the role played by endowments and other charitable gifts in the development of Northern Ireland's hospital system. The 1948 Act said that endowments should be transferred to HMCs, but those held by the Robinson Memorial Hospital in Ballymoney were only transferred to North Antrim HMC at the start of the 1960s.⁸⁰ The accounts also exclude the income derived from endowments held by the Mater Infirmorum. This

⁷⁶ Dundas, *Scottish Hospital Endowments Research Trust*, p. 52.

⁷⁷ SHHD, *Hospital endowments*, paras. 7, 39.

⁷⁸ SHT, *First report*, paras. 1–7.

⁷⁹ Health Services Act (Northern Ireland), 1948, sections 25, 28; NIHA, *Summary of accounts of endowments and gifts for the period from 1 August 1951 to 31 March 1956*, para. 1.

⁸⁰ Gray, 'Government and the administration of hospital services', pp. 163–4; NIHA, *Thirteenth Annual Report*, para. 9.

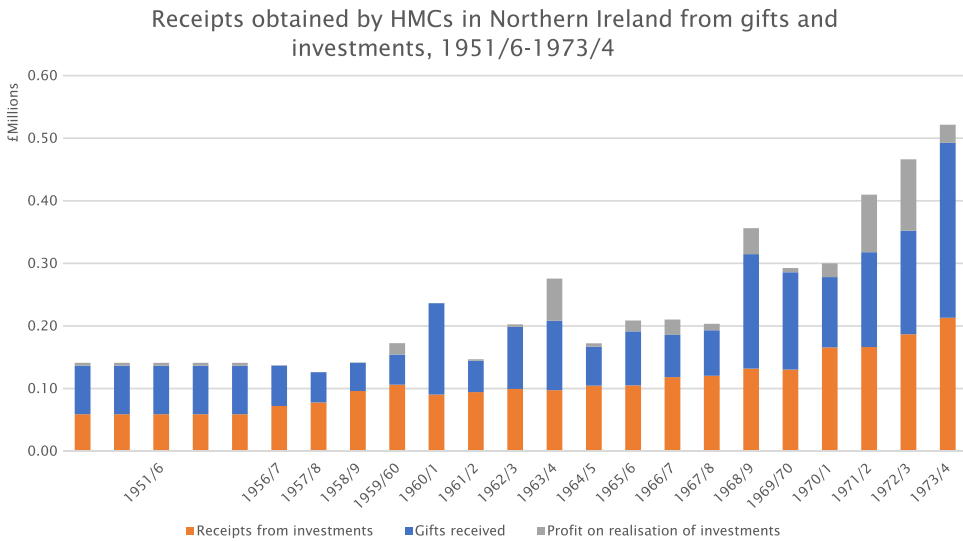


FIGURE 3 Receipts obtained by hospital management committees (HMCs) in Northern Ireland from gifts and investments, 1951/6–73/4. *Note:* The Northern Ireland Hospitals Authority (NIHA) did not publish separate figures for each of the individual years between 1951 and 1956. *Source:* NIHA, Summaries of accounts of endowments and gifts, 1951–74. [Colour figure can be viewed at [wileyonlinelibrary.com](https://onlinelibrary.wiley.com/doi/10.1111/ehr.13280)]

only joined the statutory health service in 1971 and its endowments were only transferred in the mid-1970s.⁸¹

IV | USES OF CHARITABLE FUNDING

Although NHS hospitals retained access to endowment income and the right to receive new gifts, the question of how these funds might be spent was largely ignored. In 1946, the Lord Chancellor suggested that hospitals might use their endowments and other ‘free moneys’ to pay for ‘those little ... trimmings which make so much difference to patients’ comfort and happiness’ but he was unable to explain what these might be, other than suggesting that they might include ‘all those additional things which mean so much to the comfort of the patient and which will have to come from private funds’.⁸²

This problem was not resolved by the wording of the 1946 Act. As one of the Ministry’s legal advisors observed, the act enabled hospital authorities to use the money they received either from the HEF or other endowments for ‘purposes relating to hospital services’ but ‘the term “hospital services” is ... nowhere defined’ and might therefore ‘extend to the application of income for any purpose which the Board or Committee in question bona fide considered to be likely to advance

⁸¹ Gray, ‘Government and the administration of hospital services’, pp. 354–457; DHSS Northern Ireland, *Summary of accounts of trust funds, 1975–6: Northern Ireland Health and Social Service Boards*, p. 5.

⁸² *Hansard* (Lords), 5th series, vol. 143, 8 October 1946, col. 8; *ibid.*, 9 October 1946, col. 105.



the efficiency or beneficence of the services provided'.⁸³ A later review also concluded that 'the term "hospital services" is not defined in the Act but ... clearly covers a wide range of purposes'.⁸⁴

The Government was particularly anxious to avoid any implication that public funds were inadequate. As the Ministry explained in December 1948, 'all ordinary expenditure is met from the Exchequer ... and hospitals are therefore in no way dependent on voluntary financial help for their normal needs'. It therefore insisted that RHBs and HMCs should neither 'directly or indirectly invite contributions'. However, this did not preclude 'the acceptance of gifts made ... by independent bodies such as the King Edward's Hospital Fund ... individuals ... or [Leagues of] Friends', providing that such bodies were 'wholly independent' of NHS structures.⁸⁵ Although this stipulation was designed primarily to protect the NHS against allegations of inadequacy, it also gave organizations such as Leagues of Friends a greater degree of autonomy. The National Association of Hospital Leagues of Friends claimed that they 'would have control over their own finances and would therefore be free to supplement in any way they wished the provisions of the NHS to the benefit of both the patients and staff'.⁸⁶

At the start of the NHS, officials argued that the primary function of the 'free moneys' held by RHBs and HMCs was to provide amenities for staff and patients. The Ministry claimed that, whilst the Exchequer was responsible for the provision of 'necessary' items, non-Exchequer funds should be used for 'luxuries'. However, as Prochaska has argued,⁸⁷ the distinctions between 'necessities' and 'luxuries', and between 'essentials' and 'amenities', were far from clear.⁸⁸

An early example of this ambiguity was provided by the question of 'comforts', such as sweets and tobacco. Before 1948, Poor Law hospitals had often provided 'sweets, tobacco, newspapers and periodicals, entertainments etc.' to their patients, but the Ministry argued that this practice should now cease, and that patients who had no means of their own should apply instead to the National Assistance Board for a 'comforts allowance'.⁸⁹ The application of this policy caused 'a great deal of disappointment and heartburning' and the Ministry conceded that such comforts should be provided. However, it continued to insist that this was not an appropriate use of Exchequer money and that the cost should therefore be borne by non-Exchequer funds.⁹⁰

The difficulty of distinguishing between luxuries and necessities was also highlighted in a discussion over library services. In 1950, the Order of St John and the British Red Cross announced that they would no longer be able to supply books to hospital libraries in England and Wales without charge,⁹¹ and it was agreed that the cost should now be borne by 'free moneys'. However, as W.O. Chatterton pointed out, 'a library service ... is definitely a part of therapy and ... could not be classed as an amenity pure and simple'. A Treasury official retorted that this 'could be true

⁸³ TNA MH170/102, Denys Buckley (Lincoln's Inn), 'Re. Hospital Endowments Fund: Opinion', 3/2/52.

⁸⁴ TNA MH170/102, 'Draft'. The paper was neither signed nor dated but appears amidst a group of papers addressing the transfer of assets from the Royal Eye Hospital to the HEF in 1959.

⁸⁵ TNA MH99/37, Ministry of Health, 'NHS: Appeals for Funds, etc.', 18/12/48 (RHB (48) 41A; HMC (48) 25A; BG (48) 23A).

⁸⁶ TNA MH99/37, *Annual Report of National League of Hospital Friends 1949-50*, p. 5.

⁸⁷ Prochaska, *Philanthropy and the hospitals of London*, pp. 227-8.

⁸⁸ See, for example, TNA MH99/14, H.A.M. Cruikshank, 'Supply of necessities in hospitals, etc.', 10/1/49; Ministry of Health, 'Supply of personal necessities to hospital patients', 31/5/49 (RHB (49) 74; HMC (49) 60; BG (49) 61).

⁸⁹ TNA MH99/14, W. Stansfield (Sheffield no. 1 HMC) to L.W. Faulkner (Sheffield RHB), 12/7/48; Ministry of Health, 'Pocket money etc. for patients' (draft), November 1948, para. 6.

⁹⁰ TNA MH99/14, Anthony Greenwood, MP, to Arthur Blenkinsop, MP, 15/3/49; Blenkinsop to Greenwood, 31/3/49.

⁹¹ In Northern Ireland, the Order of St John and the Red Cross continued to supply library books throughout the lifetime of the NIHA. See, for example, NIHA, *25th Annual Report*, pp. 56-7.



of anything on which endowment income could be spent' and doubted whether the matter was worth pursuing.⁹² Nevertheless, in 1951 the Treasury did agree to the use of Exchequer funds for the purchase of newspapers and magazines in mental hospitals and mental deficiency institutions on the grounds that these 'have a definite therapeutic value'.⁹³

This debate also had wider implications for the relationship between the two sets of funds. As the Treasury's Edward Hale argued, 'if therapeutically-beneficial amenities must be provided out of taxation, we seem to reach a position in which there is no field of patients' amenities which is suitable for the expenditure of endowment income', and this raised the question of what this income should be used for.⁹⁴ Meanwhile, if there was no hard-and-fast line between items which could be funded out of free moneys and items which could be funded by the Exchequer, free money might also be used to provide services which the Exchequer itself would have funded under other circumstances.⁹⁵ As the Guillebaud Committee concluded, 'if a hospital authority wishes to improve the furnishings or the standard of building construction in a new wing or hospital department, which would cost more than the amount of Exchequer money available at the time, we think it entirely appropriate that the hospital authority should finance the "element of improvement" out of their non-Exchequer funds ... if the terms of the Trusts permit'.⁹⁶

The use of free moneys to fund staff amenities also posed problems. The Ministry's legal advisor argued that free money could be used 'for any purpose which the Board or Committee ... considered ... likely to advance the efficiency or beneficence of the services provided'. This might include 'loans to members of staff in financial difficulty' or even 'the purchase of a house for an ex-employee' or 'loans to members of staff for the purposes of cars', although it excluded 'the provision of cocktail parties and tea parties for doctors, surgeons and others leaving to take up appointment elsewhere'.⁹⁷ The Treasury argued that free money could also be used to fund the provision of sports facilities but not for purposes of staff insurance, since this was provided separately.⁹⁸

Although many of these problems applied to all types of hospitals, the teaching hospitals posed additional issues. Bevan wanted teaching hospitals to retain their endowments because they engaged in research, and this was one of the central purposes stipulated in the act.⁹⁹ However, as Trevelyan explained, this decision also meant that a small number of institutions had access to resources which could be used for much larger initiatives, 'and there have been examples of expenditure being met from these funds to save administrative delay which would have resulted in securing approval to the expenditure being met from public funds'.¹⁰⁰

This issue was highlighted by the debates which accompanied the construction of Guy's Hospital Tower, which was described as the tallest hospital building in the world on its completion

⁹² TNA T227/888, Chatterton to Mitchell, 3/7/50.

⁹³ TNA T227/888, Graham (DHS) to Mitchell (Treasury), 15/8/51; Mitchell to Graham, 20/8/51.

⁹⁴ TNA T227/888, Hale (Treasury) to Edwards (Ministry of Health), 17/7/50. Hale had previously been a somewhat reluctant member of the Beveridge Committee on Social Insurance and Allied Services (see Fraser, *Beveridge Report*, pp. 56–8).

⁹⁵ TNA T227/888, Edwards to Hale, 4/8/50.

⁹⁶ HMSO, *Report of the Committee of Enquiry into the Cost of the National Health Service*, p. 382.

⁹⁷ TNA MHI70/102, Buckley, 'HEF: Opinion', 3/12/52; see also Musson (Ministry of Health) to Richards (Charity Commission), 20/5/52.

⁹⁸ TNA T227/889, Dubery (Treasury) to Bland (DHS), 27/8/59.

⁹⁹ See, for example, NHS Act, 1946, sections 7 (2), 7 (4), 7 (6), 59 (1).

¹⁰⁰ Trevelyan, *Voluntary service and the state*, pp. 63, 113; see also Owen, *English philanthropy*, p. 545.



in 1974.¹⁰¹ The hospital had prepared an initial building plan in 1947 and submitted a revised proposal to the Ministry of Health in 1961. It used its endowment fund to investigate hospital designs in Denmark, Germany, Italy, Switzerland, and the United States and, in 1965, it offered to provide 'substantial financial assistance' from the Fund to enable the project to be completed at an early date. It was therefore able to use its endowment money to expedite building progress and – arguably – bounce the Ministry into giving approval.¹⁰²

Although the Ministry wanted to ensure that 'free money' was not spent inappropriately, it recognized that 'our regulation-making power ... is limited to income derived from the central fund [i.e. the HEF]. We cannot control the use made by RHBs and HMCs of other free money and we have no control over Board[s] of Governors'.¹⁰³ This problem was compounded by the rather inconsistent ways in which expenditure was reported. In 1950/1, Mid-Glamorgan HMC spent £1973 on 'Hospital purposes and research', but this sum included £1897 for staff and patient amenities.¹⁰⁴ Other HMCs, such as Rhymney and Sirhowy Valleys, simply provided itemized lists of expenditure under such headings as Christmas extras, staff entertainments, sports equipment, cinematograph accessories and film hire, and 'other items'.¹⁰⁵ North Wales Mental Hospital HMC spent just over £1676 on medical equipment for research, the library, gramophone and records, furniture, bus hire, concerts, hire of films, sports equipment, grants to patients and staff, and 'miscellaneous' items.¹⁰⁶

The problems involved in accounting for the use of free money were also reflected in the Comptroller and Auditor-General's *Annual Reports*. Initially, the only categories were 'patient and staff amenities', 'hospital purposes or research', and 'other'. In 1954/5, the categories of 'hospital purposes' and 'research' were separated, and 'patient amenities' and 'staff amenities' were reported separately from 1957/8. In 1966/7, the category of 'hospital purposes' was abandoned altogether and a new category of 'contributions to hospital capital expenditure' was introduced.

Despite these limitations, the Comptroller's *Reports* highlight the main differences between teaching and non-teaching hospitals. As we can see from figure 4a,b, RHBs and HMCs spent approximately one-third of their free moneys on staff and patient amenities over the period as a whole, and approximately 23 per cent of their free money on contributions to capital expenditure from 1966/7 onwards. Boards of Governors spent a much smaller proportion of their money on staff and patient amenities (approximately 13 per cent over the period as a whole) and much larger proportions on either research (29 per cent between 1954 and 1974) or contributions to capital expenditure (30 per cent between 1966 and 1974). Figure 5a,b shows the same information after allowing for changes in NHS prices. The real value of the expenditure incurred by RHBs and HMCs increased by approximately 46 per cent between 1951/2 and 1973/4, whilst expenditure by Boards of Governors increased by 127 per cent over the same period.¹⁰⁷

¹⁰¹ The hospital derived much of its wealth from donations made by Thomas Guy and Henry Clayton in the eighteenth century. Both Guy and Clayton amassed substantial fortunes from their involvement in the slave trade [see Our history – Guy's & St Thomas' Foundation (gsttfoundation.org.uk) for further details]. See also Bhambra, 'Relations of extraction'.

¹⁰² Arnold-Forster and Gorsky, 'Negotiating the border'.

¹⁰³ TNA MH170/102, Chatterton, 28/10/50.

¹⁰⁴ TNA BD18/255, Norman Hurst (Finance Officer, Mid-Glamorgan HMC) to Treasurer, Welsh RHB, 19/6/51.

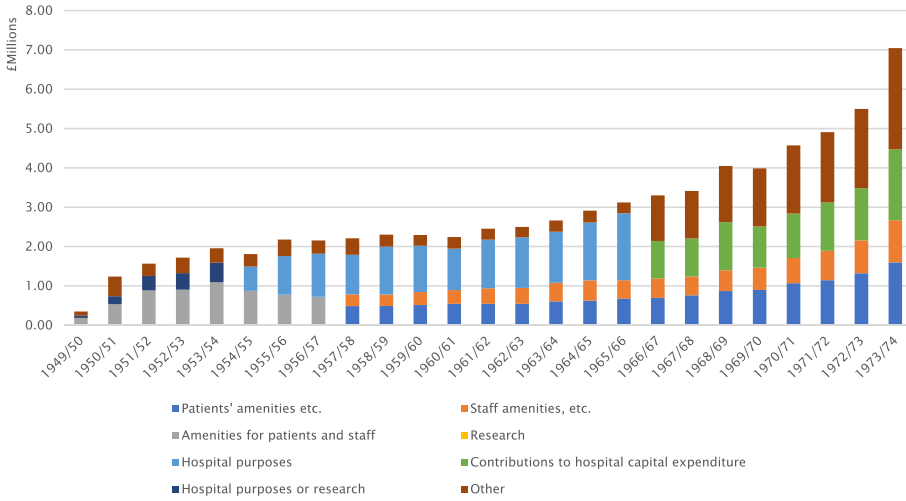
¹⁰⁵ TNA BD18/2555, Finance Officer, Rhymney and Sirhowys HMC, to Treasurer, Welsh RHB, 20/6/51.

¹⁰⁶ TNA BD18/2555, S.L. Frost, Secretary and Finance Officer, North Wales Mental Hospital HMC, to Treasurer, Welsh RHB, 21/6/51.

¹⁰⁷ It is more difficult to compare expenditure levels in the years immediately following the creation of the NHS because Boards of Governors were already able to spend money whilst the allocation of money from the HEF was still being



(a) Expenditure from non-Exchequer sources: RHBs and HMCs (current prices)



(b) Expenditure from non-Exchequer sources: BGs (current prices)

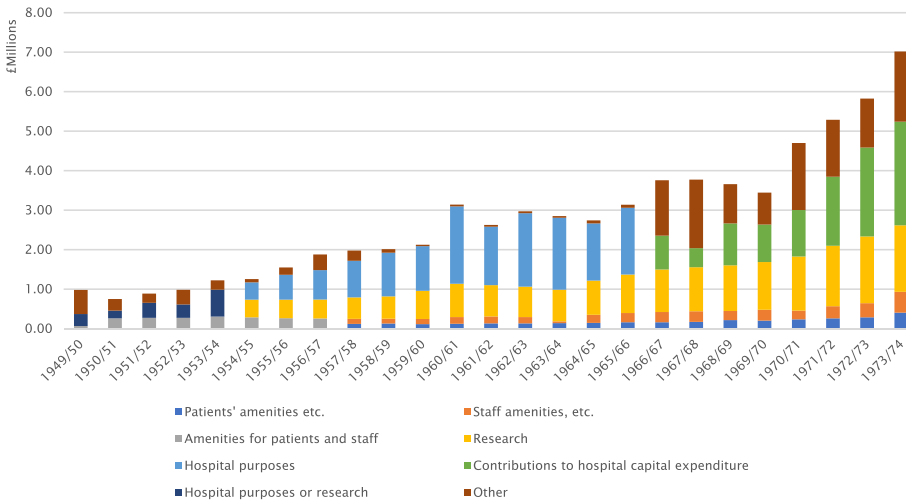


FIGURE 4 (a) Expenditure from non-Exchequer sources: RHBs and HMCs (current prices), (b) Expenditure from non-Exchequer sources: BGs (current prices). *Sources:* See figure 1. [Colour figure can be viewed at wileyonlinelibrary.com]

The framework for the distribution of endowments and other ‘free moneys’ in Scotland was set by the HEC in 1955, and overall responsibility resided subsequently with the DHS and SHHD. As Stewart argued, successive governments were largely content to allow the Scottish NHS to develop independently.¹⁰⁸ However, both the DHS and the SHHD sought to coordinate policies with both the Ministry of Health and Treasury.

finalized. The comparison is based on an index of NHS prices derived from the [Report of the Royal Commission on the NHS](#) (table E8).

¹⁰⁸ Stewart, ‘The National Health Service in Scotland.’

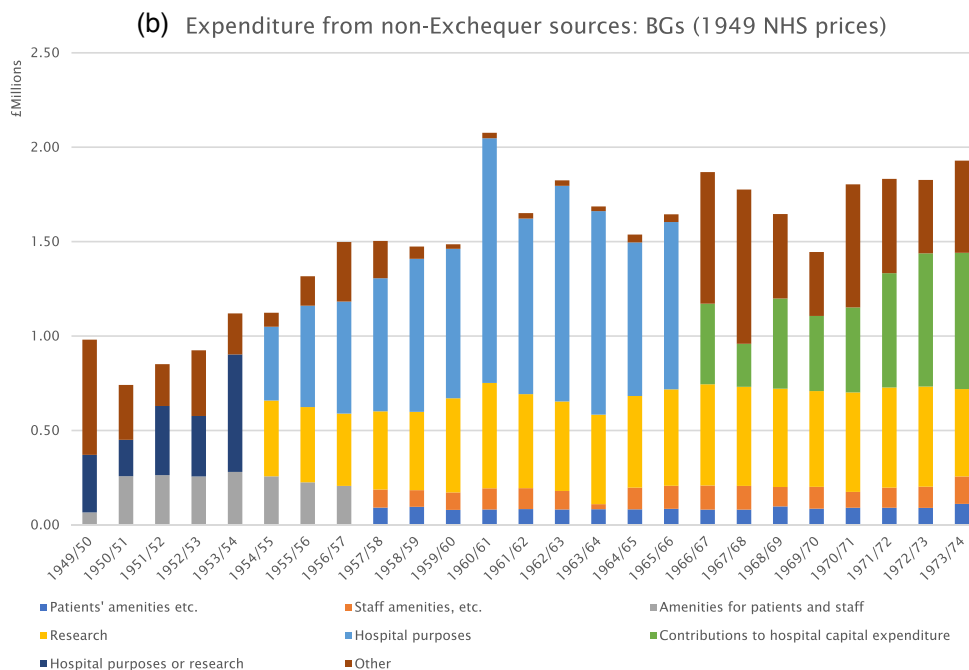
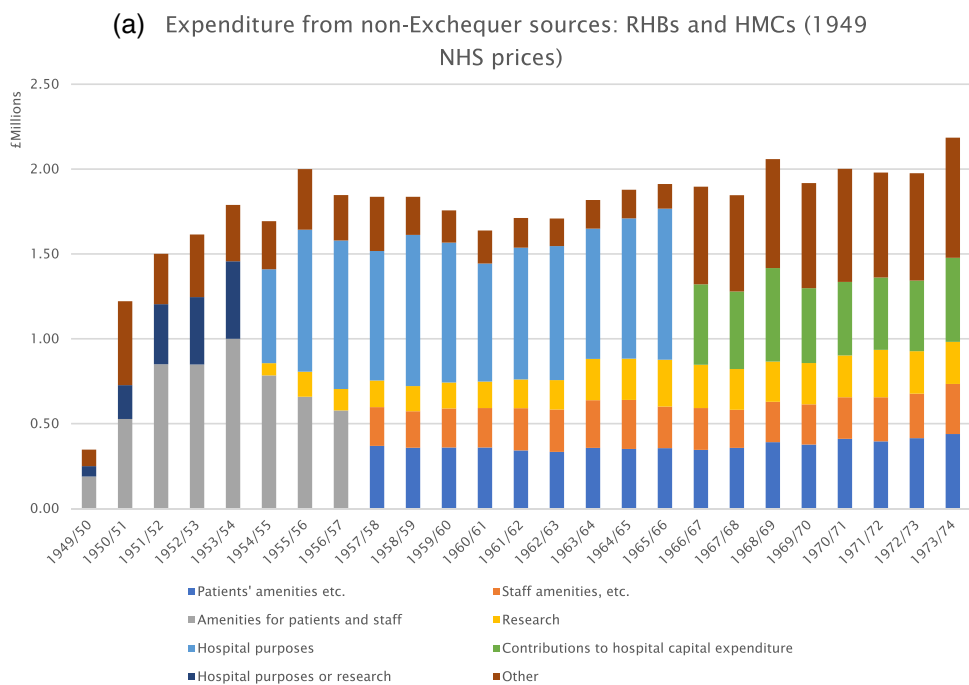


FIGURE 5 (a) Expenditure from non-Exchequer sources: RHBs and HMCs (1949 NHS prices), (b) Expenditure from non-Exchequer sources: BGs (1949 NHS prices). *Sources:* See figure 1. [Colour figure can be viewed at wileyonlinelibrary.com]



Although the Scottish NHS was established under separate legislation, the basic principles governing the use of endowments and other free moneys were broadly similar. As Arthur Woodburn, the Secretary of State for Scotland, explained in June 1949, 'with the introduction of the NHS many of the purposes to which endowment funds had previously been devoted became the responsibility of the state. There had been placed on the Commission the onerous duty of the redistribution of the funds thus released to the best advantage of the community. ... He himself would commend in particular ... the supplementing of hospital outpatient department amenities and the furtherance of medical research'.¹⁰⁹ However, when the Commission produced its final report in 1955, it recognized that even though 'the erection of buildings for hospital purposes was essentially a function of the Secretary of State ... we thought it right that Boards should not be precluded from applying endowments for building purposes'.¹¹⁰

The DHS also recognized that the concept of 'amenities' was itself rather vague and that the boundaries between items which might be financed out of free money and from the Exchequer were also unclear. This issue was compounded by the possibility that the needs of patients in different types of institution might also vary. In 1951, the Department identified a number of items which should only be funded voluntarily. These included flowers, Christmas gifts for adults, library facilities and newspapers for patients, and newspapers and periodicals, wirelasses, Christmas functions, dances, and film shows and concerts for staff. However, other items could be financed out of public money if no other funds were available. These included concerts and film shows for patients in long-stay institutions, Christmas gifts for children, Christmas dinners, wirelasses, visitors' chairs, and 'reasonable recreational facilities' for patients, and 'reasonable sports facilities', nurses' prizes and medals, and transport to recreational venues for staff.¹¹¹

Although neither the DHS nor the SHHD published annual accounts, the SHHD Working Party on the Allocation of Hospital Endowments summarized the money expended from endowment accounts over the period 1964/5–1966/7 (table 6). In addition to demonstrating the disadvantaged position of hospitals for mental illness and mental deficiency, it also showed that Scottish Boards of Management spent approximately 15 per cent of their endowment income on staff and patient amenities and 4 per cent on research. This was in addition to the sums already provided through the SHERT. A total of 9.8 per cent of endowment income was spent on medical and surgical equipment and more than 23 per cent on hospital buildings.

As we have already seen, the Northern Ireland Government was especially anxious to preserve voluntary involvement in the health service and this was reflected in the NIHA reports. Both the second and third annual reports noted that 'hospitals continued ... to receive gifts and in some cases these were substantial'¹¹² and the Authority recorded the role played by the Order of St John and the British Red Cross in providing libraries from 1949/50 onwards.¹¹³ Individual HMCs also made occasional references to the provision of specific items out of free funds. In 1959, Downshire HMC reported that it had spent £3951 from its Endowment and Gifts Fund on the running of a

¹⁰⁹ NRS HH96/1. HEC: Minutes of first meeting, 10/6/49, para. 1.

¹¹⁰ DHS, *Hospital endowments*, para. 26. In 1962, the *Hospital Plan for Scotland* recorded that the Northern RHB intended to use its endowment fund to support the construction of a new out-patient department at the Royal Hospital for Sick Children in Aberdeen (DHS, *Hospital Plan*, para. 114).

¹¹¹ TNA T227/888, 'Financial responsibility for amenities and welfare of patients and staff' (SRB 51 (32)), 4/6/51.

¹¹² NIHA, *Second Annual Report*, p. 74; NIHA, *Third Annual Report*, p. 92.

¹¹³ See, for example, NIHA, *26th Annual Report*, pp. 56–7.

**TABLE 6** Payments made by Scottish Boards of Management from endowment funds, 1964/5–66/7.

Number of beds Type of expenditure	Hospitals for mental illness and mental deficiency		All other hospitals		Total	
	27 185		37 792		64 977	
	£	%	£	%	£	%
1. Equipment	67 425	30.09	466 892	40.00	534 317	38.40
1a. Medical and surgical	4508	2.01	131 831	11.29	136 339	9.80
1b. Other equipment, furniture, etc. (including wireless and TV)	62 917	28.08	335 061	28.71	397 978	28.60
2. Buildings, alterations, and maintenance of property	42 512	18.97	285 052	24.42	327 564	23.54
3. Amenities	56 065	25.02	150 408	12.89	206 473	14.84
3a. Staff only	8948	3.99	31 165	2.67	40 113	2.88
3b. Staff and patients	17 647	7.88	73 814	6.32	91 461	6.57
3c. Patients only	29 470	13.15	45 429	3.89	74 899	5.38
4. Administration	3782	1.69	24 441	2.09	28 223	2.03
5. Study courses	13 767	6.14	63 292	5.42	77 059	5.54
6. Research projects	3821	1.71	58 210	4.99	62 031	4.46
7. Salaries and wages	2861	1.28	13 521	1.16	16 382	1.18
8. Vehicles	4412	1.97	5448	0.47	9860	0.71
8a. Board use	2250	1.00	306	0.03	2556	0.18
8b. Individual use	2162	0.96	5142	0.44	7304	0.52
9. Insurance of personnel against accidents	218	0.10	651	0.06	869	0.06
10. Hospitality	7678	3.43	22 565	1.93	30 243	2.17
11. Donations to Hospital Centre	3041	1.36	19 968	1.71	23 009	1.65
12. Unallocated	18 473	8.24	56 795	4.87	75 268	5.41
Total	224 055	100.00	1 167 243	100.00	1 391 298	100.00

Source: SHHD, *Hospital endowments*, para. 14.

patients' canteen and Ulster HMC used its fund to support the cost of constructing two houses in conjunction with a new hospital in 1961.¹¹⁴

Although the majority of the contributions made by these funds were relatively minor, the Authority placed very few restrictions on their use. Both the second and third reports highlighted the fact that 'gifts ... are available for spending at the discretion of the appropriate committee' subject only to 'the wishes ... of the donors and ... the provisions of the Act'.¹¹⁵ The Act also ensured that endowments would continue to be associated with the hospitals for which they were originally intended and this meant that a small number of institutions retained access to substantial amounts of money, and they appear to have had few qualms about using them to supplement statutory funds.

The NIHA detailed the contributions which 'free funds' had made to various hospital building projects from 1952–60 and 1966–72. Whilst some of these, such as wireless installations, the

¹¹⁴ NIHA, *Twelfth Annual Report*, Belfast, p. 41; NIHA, *Fourteenth Annual Report*, p. 47.

¹¹⁵ NIHA, *Second Annual Report*, p. 74; NIHA, *Third Annual Report*, p. 92.



construction of a nurses' recreation hall and a relatives' rest room, are broadly consistent with the types of amenities outlined by the DHS in 1951, others are much more difficult to distinguish from 'core' medical and surgical services. For example, Belfast's Royal Victoria Hospital used its 'free funds' to support the construction of a neurosurgical operating theatre and ward unit in 1953, an angiocardiology department in 1954, a metabolic department and dermatology ward in 1957, a cardiac catheterization unit in 1958, improvements to an operating suite in 1960, and a new outpatient centre in 1969. The Royal Belfast Hospital for Sick Children used its 'free funds' to help pay for the construction of new operating theatres in 1971.¹¹⁶

These payments also reflected the extent to which endowment and gift funds were concentrated in a small number of institutions. During the period 1950–64, the NIHA published details of the sums expended out of both general and free funds by each HMC. Although the data are incomplete, they suggest that 'free funds' were responsible for approximately 1.3 per cent of total HMC expenditure across the period. However, they accounted for more than 5 per cent of the sums expended by Belfast's HMC, which included the Royal Victoria Hospital, Royal Maternity Hospital, and Royal Belfast Hospital for Sick Children, and 4.91 per cent of the sums expended by Forster Green HMC. These hospitals accounted for approximately 70 per cent of 'free fund' expenditure overall.¹¹⁷

V | CONCLUSIONS

As Trevelyan argued, voluntary service continued to play an important role in the development of the health service, and this included the provision of financial support.¹¹⁸ Much of this was related to the preservation of pre-war hospital endowments, but hospitals also attracted new gifts and donations and the value of these donations increased over time. Although the post-war Labour government had limited the involvement of hospital authorities and staff in fundraising activities, the Conservatives began to relax these restrictions in 1952 and officials endorsed the use of hospital grounds for fundraising in 1959. Both Conservative and Labour governments wanted to restore the financial health of the HEF, and Labour also wanted to do this in ways which did not damage future fundraising potential.

Although policymakers were anxious to maintain the flow of charitable contributions, the income from these sources failed to keep pace with health service expenditure over the period as a whole. This is illustrated by table 7, which compares income from charitable sources and other forms of non-Exchequer income with the growth of health service expenditure in England and Wales between 1950/1 and 1973/4. However, contributions from charitable sources were not always 'peanuts'.¹¹⁹ During the 1950s, income from subscriptions, grants, donations, and other charitable sources was equivalent to more than 3 per cent of the total expenditure of the

¹¹⁶ These details are taken from the *Annual Reports* of the NIHA for 1953, 1954, 1957, 1958, 1960, and 1971.

¹¹⁷ These calculations are based on data published in the *Annual Reports* of the NIHA for 1950/1–64. The following HMCs indicated that they had spent unspecified amounts of money from their 'free funds' in specific years: Banbridge and Dro-more HMC: 1952, 1953; Belfast HMC: 1951/2, 1953; Coleraine and Portrush, 1953; Fermanagh: 1950/1; North Antrim HMC: 1950/1; North-West HMC: 1952, 1953; Samaritan HMC: 1953; Ulster HMC: 1952, 1953. If the analysis is confined to the period 1954–64, 'free funds' accounted for 5.5% of total expenditure by Belfast HMC and 5.53% of total expenditure by Forster Green HMC; and these two HMCs were responsible for 69.91% of 'free fund' expenditure overall.

¹¹⁸ Trevelyan, *Voluntary service and the state, passim.*; see also Owen, *English philanthropy*, pp. 545–6.

¹¹⁹ Cf. Prochaska, *Philanthropy and the hospitals of London*, pp. 226–7.



TABLE 7 Income from non-Exchequer sources and NHS expenditure: England and Wales, 1950/1-73/4.

	Expenditure (£000)										Income from subscriptions, grants, etc. as % of expenditure							
	Non-Exchequer income (£000)					NHS												
	RHBs & HMCs		Boards of Governors		Total	Subscriptions, grants, etc.		Other		Total		RHBs & HMCs	Boards of Gov-ernors	NHS total	Total			
1950/51	2737	71	2808	2904	22	2926	5641	93	5734	183 662	32 984	216 646	181 633	398 279	1.49	8.80	2.60	1.42
1951/52	2536	204	2740	1966	555	2521	4502	759	5261	200 892	33 591	234 483	176 220	410 702	1.26	5.85	1.92	1.10
1952/53	2405	298	2703	648	1,001	2649	4053	1299	5352	217 702	36 152	253 854	196 965	450 819	1.10	4.56	1.60	0.90
1953/54	2241	390	2631	1581	827	2408	3822	1217	5039	228 927	37 240	266 167	166 494	432 661	0.98	4.25	1.44	0.88
1954/55	2427	519	2946	1568	745	2313	3995	1264	5259	241 201	38 840	280 041	173 561	453 602	1.01	4.04	1.43	0.88
1955/56	2389	745	3134	1558	814	2372	3947	1559	5506	262 625	41 915	304 540	186 693	491 233	0.91	3.72	1.30	0.80
1956/57	2512	901	3413	1628	1192	2820	4140	2093	6233	288 710	45 719	334 429	203 376	537 806	0.87	3.56	1.24	0.77
1957/58	2555	920	3475	2002	1283	3285	4557	2203	6760	313 019	48 798	361 817	210 986	572 803	0.82	4.10	1.26	0.80
1958/59	2127	999	3126	1810	746	2556	3937	1745	5682	333 222	51 722	384 943	231 027	615 970	0.64	3.50	1.02	0.64
1959/60	2799	539	3338	1820	765	2585	4619	1304	5923	357 823	55 214	413 037	222 189	635 226	0.78	3.30	1.12	0.73
1960/61	2613	502	3115	2151	735	2886	4764	1237	6001	396 004	63 825	459 829	252 787	712 616	0.66	3.37	1.04	0.67
1961/62	2667	535	3202	1947	705	2652	4614	1240	5854	424 459	67 237	491 696	239 441	731 138	0.63	2.90	0.94	0.63
1962/63	2773	483	3256	2000	929	2929	4773	1412	6185	450 865	70 785	521 650	274 153	795 804	0.62	2.83	0.91	0.60
1963/64	3192	529	3721	2601	911	3512	5793	1440	7233	496 923	79 816	576 739	284 408	861 148	0.64	3.26	1.00	0.67
1964/65	3257	591	3848	2706	1103	3809	5963	1694	7657	535 064	87 794	622 858	323 311	946 169	0.61	3.08	0.96	0.63
1965/66	3478	606	4084	2690	1096	3786	6168	1702	7870	591 484	96 886	688 369	380 129	1 068 498	0.59	2.78	0.90	0.58
1966/67	3807	586	4393	2744	1204	3948	6551	1790	8341	633 168	108 984	742 152	426 797	1 168 949	0.60	2.52	0.88	0.56
1967/68	4217	582	4799	2839	1285	4124	7056	1867	8923	680 965	122 374	803 340	474 779	1 278 118	0.62	2.32	0.88	0.55
1968/69	4699	604	5303	3014	1581	4595	7713	2185	9898	730 463	140 874	871 337	488 733	1 360 071	0.64	2.14	0.89	0.57
1969/70	5274	653	5927	3480	1417	4897	8754	2070	10 824	789 075	159 456	948 531	536 783	1 485 314	0.67	2.18	0.92	0.59

(Continues)



TABLE 7 (Continued)

	Non-Exchequer income (£000)				Expenditure (£000)				Income from subscriptions, grants, etc. as % of expenditure								
	RHBs & HMCs		Boards of Governors		RHBs & HMCs		Boards of Governors		RHBs & HMCs	Boards of Gov-ernors	NHS total						
	Subscriptions, grants, etc.	Total	Subscriptions, grants, etc.	Total	Other NHS	Total	Other NHS	Total									
1970/71	5119	5744	3209	1544	4753	8328	2169	10 497	931 232	185 257	1 16 489	616 592	1 733 081	0.55	1.73	0.75	0.48
1971/72	5398	6056	3881	1837	5718	9279	2495	11 774	1 122 667	204 763	1 327 430	627 240	1 954 671	0.48	1.90	0.70	0.47
1972/73	6362	6928	3856	1759	5615	10 218	2325	12 543	1 299 593	231 798	1 531 391	691 512	2 222 904	0.49	1.66	0.67	0.46
1973/74	7709	8439	4909	1698	6607	12 618	2428	15 046	1 497 472	268 554	1 766 027	755 974	2 522 000	0.51	1.83	0.71	0.50

Note: Income from 'Subscriptions, grants, etc.' includes income from subscriptions, grants, and donations; gifts, interests, and legacies; and dividends and interest on endowments (including HEF income); 'Other income' includes income from property and estates, asset realization, and other income; 'Other NHS expenditure' includes all expenditure not accounted for by either RHBs, HMCs, or Boards of Governors, such as expenditure on local authority health and general practitioner services. Sources: For details of non-Exchequer income and expenditure by RHBs, HMCs, and Boards of Governors, see figure 1. Data on total NHS expenditure were derived from the Civil Appropriation Accounts, 1948/9–73/4.



Anglo-Welsh teaching hospitals, and the value of these sums to individual hospitals was likely to have been much greater.

When the NHS was established, Ministers argued that the state should take responsibility for the provision of ‘core’ services and that ‘free moneys’ should only be used for amenities and research. However, it was hard to draw a line between ‘amenities’ and other services, and many hospitals also used their endowments and gifts to pay for capital investment and construction projects. This was especially true in Northern Ireland, where a small number of especially well-endowed hospitals used their ‘free funds’ to pay for overtly medical and surgical initiatives.

Although the value of charitable donations has grown significantly in recent years, many of the problems and ambiguities which characterized the role of charity in the early years of the NHS have not been resolved. In 2021, following the death of Captain Tom Moore, the BBC reported that ‘the focus of [NHS] Charities Together is the comfort and wellbeing of staff and patients – things that, in the words of one NHS worker, “make their working lives easier”’.¹²⁰ However, fundraisers have also argued that charitable income can be used to ‘donat[e] state-of-the-art technologies’¹²¹ and purchase ‘life-saving equipment’.¹²² These somewhat contradictory statements highlight the extent to which arguments over the boundaries between the provision of ‘core’ and ‘non-core’ services, and between the responsibilities of civil society and the state, have not gone away.

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DATA AVAILABILITY STATEMENT

The archival data that support the findings of this study are openly available in UK National Archives at <https://www.nationalarchives.gov.uk/> and at the National Records of Scotland (<https://www.nrscotland.gov.uk/>).

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¹²⁰ Shearing, ‘Capt. Tom donations’.

¹²¹ NHS Charities Together, *Annual Report 2021*, p. 5.

¹²² Bristol Children’s Hospital Charity, *The Grand Appeal Annual Report*, p. 5.



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