VOLUNTARY SERVICE AND THE STATE

A Study of the Needs of the Hospital Service

Published by
Geo. Barber and Son, Ltd.,
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The National Council of Social Service (Incorporated)
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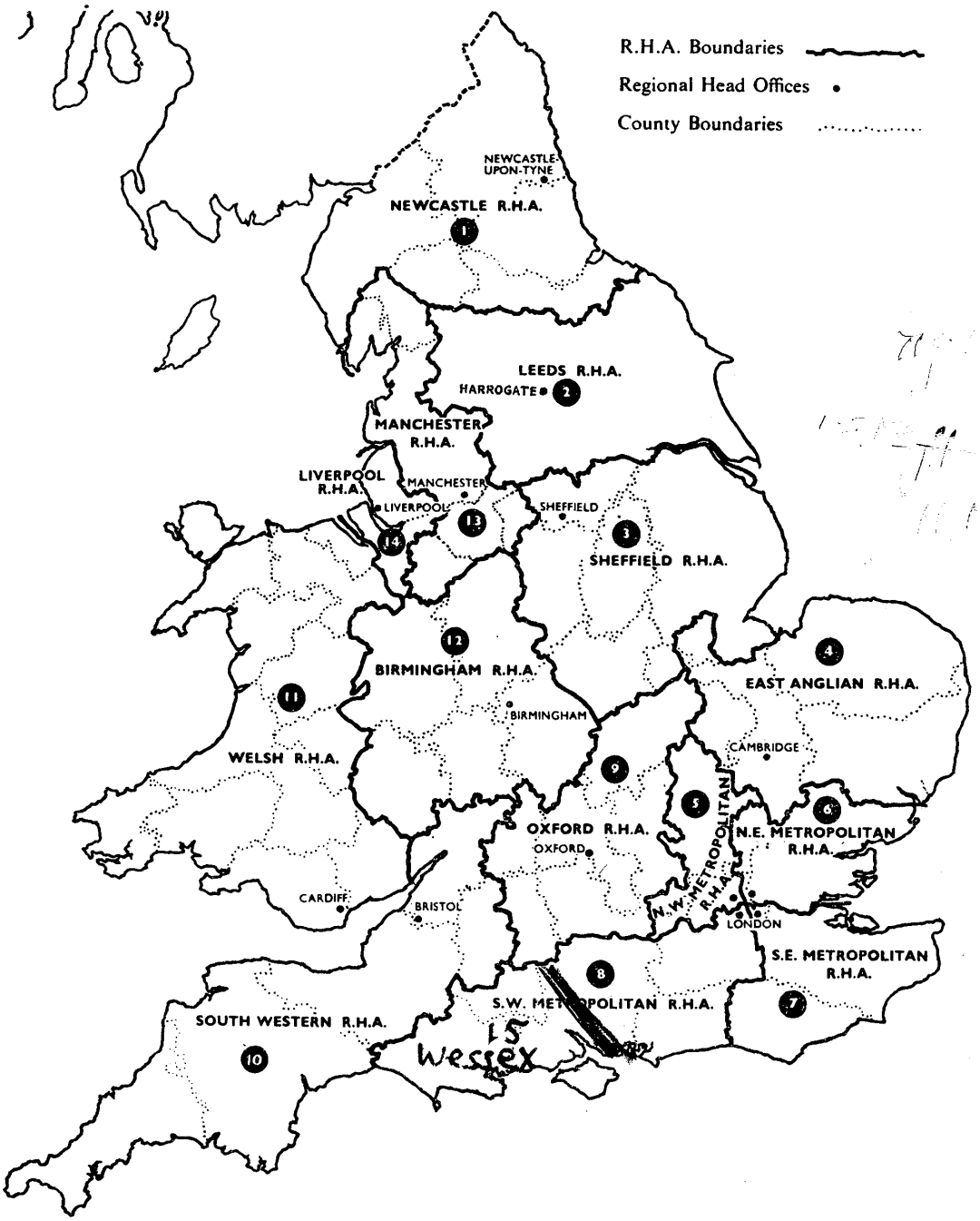
MAP OF HOSPITAL REGIONS
in England and Wales



Preface

VOLUNTARY social services and the activities of voluntary organisations are undergoing a profound change as a result of new social legislation. It is generally agreed that the volunteer and voluntary organisations have still an important part to play in the life of the community: this assumption is implicit in much of the new social legislation, but the provision for the effective use of voluntary effort is usually of a general kind and the powers largely permissive. It is clear that the future of voluntary effort will be greatly influenced by the use which is made of these permissive powers and by the methods which are adopted both by the authorities and by the voluntary organisations in working out a new partnership.

If voluntary initiative and the work of voluntary organisations are to retain and develop an important place in community life, the situation must be kept under careful review during the next few years as the new services become established. It is important, for example, to see the trend of administrative decisions taken by different authorities and their executive officers. It is also important to know what new initiative is being exercised by voluntary bodies. There is general agreement that the role of the pioneer remains: in what ways is this true and what striking manifestations of it are appearing?

As almost all the hospitals of the country were taken over by the State in 1948, *they seemed to offer the best field for an immediate study of these questions, and in January,* 1950, *the National Council of Social Service, with the support of King Edward's Hospital Fund for London, decided to promote an Enquiry into the future of voluntary activity in the new hospital service. They were fortunate in securing as the Director of the Enquiry* MR. JOHN TREVELYAN, O.B.E., M.A., *formerly Director of Education for the County of Westmorland, who has been responsible for making a survey of the problem and for writing the report. An Advisory Committee was also appointed and has been in close touch with the Director at each stage of the survey, considering carefully the reports and papers which were prepared as the work progressed. The members of the Committee, whose membership is listed overleaf, do not necessarily agree with every statement in the report, but they commend the report and the conclusions which it contains to the earnest consideration of all who are responsible for the future of the hospital service and of the voluntary agencies and voluntary workers who still have so important a role to play in the hospital field.*

The Committee has not itself interviewed witnesses or received evidence from outside sources, but, in advising the Director, it has drawn upon the wide experience of its own members in the field of hospitals and public health and in social work. It has also received the help and guidance of Mr. G. E. Haynes, C.B.E., General Secretary of the National Council of Social Service, and Mr. A. G. L. Ives, M.V.O., Secretary of King Edward's Hospital Fund for London.

Mr. Trevelyan and his staff have spared no pains in securing by visit and interview a wide sample of opinion and experience in many grades of the hospital service, and the Committee feels that this difficult task, carried out with a sense of some urgency, has been admirably discharged.

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MR. STEPHEN F. BURMAN, M.B.E.

Chairman of the Board of Governors of The United Birmingham Hospitals. A Vice-Chairman of the Teaching Hospitals Association.

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Acknowledgments

THE Committee wish to express their thanks to all who have helped them and the Director in this Enquiry. They greatly appreciate the help given by officers of the Ministry of Health, by members and officers of Regional Hospital Boards, Hospital Management Committees, and of Boards of Governors of teaching hospitals, and by members and officers of many voluntary societies. Throughout this Enquiry the staff have met with encouragement, co-operation, and readiness to help.

The Committee also wish to record their appreciation of the services of the staff who have helped in the preparation of this report—to Mr. A. C. Stuart-Clark, M.A., and Miss Jan Choyce, who have collected much of the information that was needed, to Mrs. Olliver, B.Sc. (Econ.) (Hons.) who has served as Secretary to the Committee and has undertaken historical research, and to Mrs. Metcher who has typed all the material.

Introduction

"THE preface of a book ought to set forth the importance of what it is going to treat of, so that the reader may understand what he is reading for." This advice given by Florence Nightingale seems to us to be admirable, and I propose to follow it.

I have undertaken, at the invitation of the National Council of Social Service and King Edward's Hospital Fund for London, to study voluntary service in the field of hospitals, and, if possible, to make suggestions for future policy. To do this I have found it necessary, with the help of my staff, to survey the administration of the new hospital service, and to study voluntary service against this background.

At the start of our work we thought it desirable to define our terms, and we carefully considered what meaning we should, for the purposes of this Enquiry, attach to the words "voluntary service." We decided that it should cover:

(*a*) service by men and women, unpaid, as members of boards and committees forming part of the administrative structure of the hospital service;

(*b*) service to hospitals, or in connection with hospitals, by paid or unpaid workers who are members of the voluntary organisations and services;

(*c*) service to hospitals, or in connection with hospitals, by men and women, unpaid, acting in an individual capacity; and

(*d*) voluntary financial subscription to hospitals, or to activities connected with the hospital service.

This definition may be said to cover any form of service in, or in connection with, the hospital service that is not directly provided or wholly financed by the State.

The present time appears to be particularly appropriate for an Enquiry of this kind. In 1948, when the National Health Service Act of 1946 came into force, the responsibility for the provision and maintenance of hospitals in England and Wales was, for the first time in our history, entrusted by Parliament to the Minister of Health. He was charged with the duty "to promote the establishment in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness," and, as a part of this health service, to provide "hospital and specialist services." The voluntary hospitals of the past, with a few exceptions, ceased to be the responsibility of the community which had supported them, and the former municipal hospitals ceased to be the responsibility of the Local Authorities. All but a few hospitals, which were excluded for special reasons, were transferred to public ownership vested in the State. The new hospital service has now been in operation for more than three years, and indications of its strengths and weaknesses are already apparent. In due course, perhaps

quite soon, adjustments will be made in the light of experience. It is therefore important that consideration should be given now to the contribution which can, and should, be made by voluntary service, so that it may be determined whether this is to continue to be a significant contribution. It must be decided whether the tradition of voluntary service associated with hospitals belongs to the past, or whether it is to be a continuing tradition in somewhat different forms.

While an examination of this question is of value in itself, it will be of more value if it is considered as a part of the wider question of the future of voluntary service in the society of our time. We live in an age of transition when new social patterns are emerging, and while the pattern of voluntary service has, to some extent, changed with changing society, it has been largely a process of *ad hoc* adjustment to meet immediate needs. Although the State has taken on new responsibilities in fields which were formerly cultivated by voluntary endeavour, voluntary service not only still exists and functions, but finds more work than ever to do. There seems to be a need for an objective examination of voluntary service in all fields of social endeavour, an examination which will provide a fair assessment of its value to society and its relevance to the new social patterns.

Voluntary service can be looked at in two ways—as something which society can make use of if it chooses, or discard if it chooses ; or as something that comes spontaneously from people and will continue to come whether society chooses to make use of it or not. In the first, voluntary service is looked at from the angle of society ; in the second, from the angle of the individual.

Looking at voluntary service from the angle of society it should, in our view, be determined whether, apart from the value of service given, it is a "capital asset" to society and therefore worthy of preservation as such ; whether it merits preservation only for a time as a useful means of improvisation, to be superseded when the need for improvisation no longer exists ; or whether it has become an anachronism in the mid-twentieth century that is surviving because of its traditions and vested interests in a society which needs it no longer.

Looking at voluntary service from the angle of the individual we should, in our view, try to determine whether the instinctive desire to be of service to others needs to be fostered, and in what fields of activity it can best be encouraged. The answers to these questions will necessarily depend on whether society chooses to make use of voluntary endeavour in the social services in which the State takes responsibilities, but rejection of voluntary service by the State would not destroy the instinctive human desire to be of service to others ; it would merely divert it into other channels. Man cannot be prevented by edict or regulation from doing good to his neighbours ; he can only be prevented from giving his services to some activity that is under State control.

We hope that this report, although it is concerned with only one field of voluntary service, will throw some light on these questions. As a field for enquiry the hospital service has much to commend it. The history of hospitals in this country is substantially a record of voluntary endeavour, and this is reflected in the National Health Service Act of 1946, which provides for the hospital service to be financed almost entirely from Exchequer funds but to be controlled and administered by a partnership between the State and voluntary service, a pattern of administration which has no direct parallel in this country. Furthermore it is a service which provides great opportunities for personal voluntary work.

We hope that the results of our work will be of interest and value to all who are concerned with the hospital service, to those who direct the policy of voluntary organisations, and to the general public, among whom are many who give their services for the benefit of hospitals. Above all we hope that they may be of ultimate benefit to the patients, for whom the hospital service exists.

JOHN TREVELYAN.

November, 1951.

PART I

CHAPTER I.

VOLUNTARY SERVICE IN SOCIETY

(a) The Changing Concept of the Role of the State

The scope of voluntary service at any one time must necessarily depend on the prevailing concept of the rôle of the State. History shows this concept to be variable, and Fromm has suggested in "The Fear of Freedom" that there is evidence of cycles of change as men seek freedom, attain it, and, fearing what they have attained, seek the security of control, only to seek freedom afresh. At any one period of history too there are examples of differing concepts in different societies, as men learn, or think they learn, from the fate of other nations.

In recent times we have seen examples of the two extremes of totalitarianism and *laissez-faire* democracy. We have seen Acton's dictum on the corruption of power exemplified not only in Nazi Germany, which accorded to the individual no function other than that of complete subjection to the State, but also in Communist Russia, with a society founded in its origins on the principle of "to each according to his need: from each according to his capacity." We have seen the democratic countries compelled by world events to limit individual freedom and increase State control. Free societies in the Western world have been seeking new ways, ways which lie between the extremes, and are shaping their societies and their concepts of the rôle of the State on the anvil of political and social experience.

In this country the so-called "Welfare State" has emerged by evolutionary process. It is based on a recognition that each member of society has certain rights and is entitled to a basic minimum standard of living and social welfare, and on an acceptance of State intervention in the lives of individual citizens so far as is necessary to secure these. One form of freedom is thus gained at the expense of another; indeed the essential problem inherent in this concept is that of the extent to which individual freedom must be surrendered in the interest of society as a whole.

This is no new problem. Much thought was given to it by the 19th century philosophers and political economists. John Stuart Mill prophesied that "it is likely soon to make itself recognised as the vital question of the future," and continued:

> "It is so far from being new that, in a certain sense, it has divided mankind almost from the remotest ages; but in the stage of progress into which the more civilised portions of the species have now entered, it presents itself under new conditions, and requires a different and more fundamental treatment."

Bentham and his followers, who were inspired by a philosophy of individualism, nevertheless through their zeal for reform advanced collectivism, and it is to them that we

owe the origins of our social services ; indeed it may fairly be said that the concept of the Welfare State owes much to Bentham, especially in its quantitive aspects of social security. It was John Stuart Mill, however, who foresaw the danger of the Welfare State, with all its benevolent intention, destroying the spirit that is born of individual freedom and fostered by individual resource and initiative. In the last chapter of his "Principles of Political Economy" he wrote :

> "A people among whom there is no habit of spontaneous action for a collective interest—who look habitually to their Government to command or prompt them in all matters of joint concern—who expect to have everything done for them, except what can be made an affair of mere habit and routine, have their faculties only half developed."

Mill saw the contribution of what we call "voluntary service" to be of fundamental importance :

> "The only security against political slavery is the check maintained over governors by the diffusion of intelligence, activity and public spirit among the governed. Experience proves the extreme difficulty of permanently keeping up a sufficiently high standard of these qualities, a difficulty which increases as the advance of civilisation and security removes one after another of the hardships, embarrassments and dangers against which individuals had formerly no resources but in their own strength, skill and courage. It is therefore of supreme importance that all classes of the community, down to the lowest, should have much to do for themselves ; that the Government should not only leave as far as possible to their own faculties the conduct of whatever concerns themselves alone, but should suffer them, or rather encourage them, to manage as many as possible of their joint concerns by voluntary co-operation ; since this discussion and management of collective interests is the great school of that public spirit, and the great source of that intelligence of public affairs, which are always regarded as the distinctive character of the public of free countries."

If this doctrine is accepted it follows that we should consider what steps need to be taken to stimulate active participation in voluntary service in all classes of the community, and also what functions in social welfare, even in a Welfare State, should be deliberately left to voluntary endeavour.

Two factors of considerable importance are the attitude of the individual to the State and the attitude of the State to the individual.

To the majority of people "the State" is a meaningless term : they are only aware of "the government" and "the official." The government is an unseen power over which they seem to have no control. It is a tragic paradox that while Socialist policy has aimed at identifying the individual with the State, the administrative machinery of government appears to have the reverse effect. The State, as represented by the government and the official, is something to fear, having the law, with its power and complexity, behind it, so that the individual seems to be at its mercy. The official too often delights in the minor authority that he is able to exercise and appears as the master rather than the servant. Even private life is not sacred : all details must be entered on the form of application.

Alongside this the State is seen as essentially a providing authority, providing in particular a great measure of "social security." Unemployment between the wars and a greater awareness of the social evils of our time produced the impulse which led to the Beveridge Report and social security. People who for years had fought for their "rights" found their claims accepted, and asked for more. Others, who had belonged to what were called "the depressed classes," became aware that they had "rights" and became interested in them. The Welfare State came into being before the mass of the people had begun to learn that as well as having "rights" they had obligations to society, and this resulted in an acceptance of all that the State offered without a corresponding readiness to make a contribution in return.

Against such a background as this it would seem that the stimulation of active participation in voluntary service for the benefit of the community might be a very difficult task. Fortunately, however, most people who give voluntary service give it not as a contribution to the State or even to the community as a whole, but, with a narrower horizon, as a contribution to their own district, town or village, or commonly to their own hospital. Even though their hospital has become part of a State service, and even though they may well adopt the attitude that the State ought to provide and pay for all that the hospital needs, there is every likelihood that they will respond to appeals for voluntary service for their hospital if it can be shown that their help is needed—the more so if they believe that in their service they are giving something to the hospital that the State cannot provide.

The State can of course provide people to do all the work that needs to be done in a hospital, but it cannot be sure of providing people whose attitude to their work is one of devoted interest, an attitude which has distinguished the hospitals in the past. It is commonly said that the employee in a State service tends to show less devoted interest to his work than the person in private employment. This is at best a generalisation. No more devoted and untiring service can be found than that given by some public servants, but there are examples of public servants who will do no more than they are required to do by the terms of their appointments. That this attitude can exist, as we have been informed, even in such an essentially human service as the hospital service, is indeed a tragedy. The person who, inspired by selfless motives, undertakes voluntary work for the hospitals does at least provide an example of the spirit of service.

The extent to which the help of the voluntary worker will be needed may well depend not only on the attitude of those in authority at the hospitals towards voluntary service, but also on the extent of encouragement given by the State. There has been a marked tendency in recent years to increasing centralisation of administrative control, with a proportionate decline in opportunities for individual endeavour, combined with a growing standardisation of policy and a decline in local variation to meet local needs. The administrative machine has become more and more important, and administrative tidiness is considered a virtue. Voluntary service does not always fit easily into the administrative machine, and unless the State is prepared to accept, and even encourage, flexible administration, individual voluntary endeavour in the social services may well decline and eventually disappear.

There are different views held on the function of the State in the social welfare of the people. Some hold the view that the State should seek to provide the best possible stand ards for all ; others that it should provide basic acceptable minimum standards, leaving it to voluntary endeavour to improve on these wherever possible. At the

present time this can only be a theoretical problem, and we are not in fact presented with a choice of policy. Economic pressure makes it difficult to reach even what would be accepted as basic minimum standards throughout the country, and there seems no likelihood of further advance in the near future. Nevertheless, even as a theoretical problem the choice should be made, since on it will depend whether voluntary service, which will be generally accepted as a useful improvisation in times of need such as the present, is to make a permanent contribution to social welfare.

John Stuart Mill wrote : "The worth of a State, in the long run, is the worth of the individuals composing it." It is to be hoped this concept of the State, the concept of it being not a deity to be worshipped, not a power to be feared, but the individuals composing it acting collectively for their mutual benefit, will be regarded by future historians as the prevailing concept of our time.

(b) Changing Conceptions of Voluntary Service

What is generally meant by "voluntary service" ? The answer that most people would give is that it is service to one's fellow men that is given without remuneration or reward. In giving this answer they would be thinking of the service given by the voluntary ambulance worker, the canteen helper, the car driver, the escort, the voluntary nurses, and many others undertaking useful public service, and doubtless they would have in their minds a picture of men and women in the uniforms of such well-known voluntary societies as the St. John Ambulance Brigade and the British Red Cross Society, and women in the uniform of the Women's Voluntary Services. Voluntary service of this kind has become a normal feature of life in this country and we are inclined to forget that it is comparatively new. It is not voluntary service itself that is new but our contemporary conception of it.

The origins of voluntary service lie in the realms of conjecture. Doubtless the natural instinct of man to give service to his neighbours existed in earliest times and was given expression in practical acts of service in primitive communities. The birth of Christianity strengthened the religious impulse which no doubt had always been a basic source of inspiration : duty towards one's neighbour became a primary Christian duty. The religious inspiration runs like a thread through the whole history of charitable endeavour and personal service and remains a powerful influence in our time despite the decline in church membership.

For many hundreds of years in this country the personal obligation to serve those in need seems to have been interpreted essentially in terms of charitable benefaction. No doubt voluntary personal service was not unknown, but few examples survive in the records of history whereas there is an extensive record of charitable benefaction. The great age of personal benefaction to hospitals was the eighteenth century, and many of the hospitals which give good service to the public to-day as part of the national health service owe their existence to charitable foundation at that time. As the century drew to a close the industrial revolution was changing the face of England and the way of life of great numbers of its people. The age of charity continued into the nineteenth century, but horizons were widening and men were beginning to see social problems as national problems. Some felt that more than charity was needed and put their energies into social reform. The extravagances of high society were a marked and obvious contrast

to the poverty which was everywhere to be seen. It was a time of opportunity for the pioneer, and the opportunity was not lost.

In every age there are great men and women who rise above the level of their time. The period of 1750 to 1900 was particularly rich in social reformers acting from the highest motives. Many of them pursued with burning zeal in the name of humanity what were then minority causes—Howard, Wilberforce, Elizabeth Fry, Shaftesbury, Octavia Hill, Florence Nightingale, to mention only a few, are names which live in history. Perhaps the reformers profited by the fact that the needs of the poor were obvious, obvious enough to prick the consciences of those whose wealth had all too often been amassed by exploitation of cheap labour.

This was not, however, the whole picture. Alongside those who dispensed charity and could afford to do so there were in every walk of society "Good Samaritans" who, having had their eyes opened to the living sores of poverty, strove with practical commonsense and remarkable energy to heal them. It is to these men and women, most of them unknown by name in our time and even in theirs, as well as to the great social reformers, that we owe the voluntary social services of our time.

The growth of civic administration brought with it increasing opportunity for voluntary service of a special kind—committee service. By the end of the nineteenth century local government as we know it to-day had come into existence and throughout the country men and women were elected to serve as members of local councils. Service of this kind became the accepted obligation of the county landowners and the prominent personalities of local trade in the towns.

Voluntary service in Edwardian times retained much of the spirit of the nineteenth century. The class structure in society was as rigid as ever—although the plutocrat was now admitted to circles that were in Victorian times open only to the aristocrat—and charity remained an accepted obligation of the privileged. Much progress had however been made in social welfare and the needs of the poor were less in evidence. The increasing emancipation of women, leading to the suffragette movement, opened new fields of activity for women and provided a new stimulus to social endeavour.

The 1914-1918 war marked a turning point. The war threw into relief the need for personal service of many different kinds, and provided new opportunities for voluntary activity. By bringing together men of all social classes under conditions of danger and discomfort it cracked the rigid class structure. It further advanced the emancipation of women, many of whom volunteered for the women's services and shared the danger and discomfort with the men. Few questioned, as they would have done in Florence Nightingale's time, the respectability of "ladies" who worked as V.A.D's, drove ambulances, and undertook all kinds of war work.

The inter-war years brought new problems, such as the need for relief in Europe, and later, at home, the desperate needs caused by mass unemployment. Voluntary organisations of all kinds responded to the challenge. Although social barriers returned to some extent, voluntary service had ceased to be charity or patronage and had become personal service by people from all walks of society to tackle urgent social problems. The spirit which had permeated nineteenth century founders of the voluntary organisations survived as an inspiration to the new forms of service.

The war of 1939-45 carried this process of change even further. The women's services not only became an integral and vital part of the fighting forces for which women were conscripted, but new services were formed to meet special needs. The

Women's Land Army, for example, provided essential labour for food production. These services were no longer voluntary services, but they may be said to have grown out of voluntary effort in the past. One service for women was closer to the pattern of voluntary organisations—the Women's Voluntary Services. It was a service and not a voluntary organisation, yet, although it was substantially financed from public funds, the majority of its members served in a voluntary capacity. It was, and still is, an example of the State and voluntary service in partnership.

In this period voluntary organisations acted in many tasks as agents of the Government, undertaking special services which were needed but which could not easily be directly provided. Throughout the war there were innumerable examples of voluntary workers serving as part of the Civil Defence Services ; voluntary and paid staff worked together with complete harmony in a common purpose.

Voluntary service became largely freed from patronage. Ambulance and rescue teams gave their services in ways which contrasted strangely with much of the nineteenth century voluntary endeavour. The class structure again weakened as people of all kinds worked together in the common purpose and common danger at home and overseas.

After the war social barriers reappeared here and there, but they were never as strong as before. The new conception of voluntary service has survived. Society has recognised that voluntary service can be efficient, and that it can and will provide services which are needed and which the Government is unable to provide, and the individual impulse to give voluntary service is as strong as it ever was when called upon to meet a real need. When the need is shown the challenge is met.

(c) Motives in Voluntary Service

The motives which influence a person to give voluntary service, like all motives which underlie human behaviour, are often complex, and any attempt to make a simple classification is liable to produce misleading results. Nevertheless, we feel that a brief reference should be made to those motives which, from our investigations, we believe to be of particular relevance to our subject.

We are faced with the difficulty that the voluntary action with which we are concerned takes widely differing forms. The motives of a person who serves on a committee naturally tend to be different from those of a person who gives personal service in a hospital. Our investigations have, nevertheless, led us to the conclusion that while there are some motives which apply to one kind of voluntary service and not to another, there are others which are common to all forms of voluntary action. Some of these motives are wholly good, some are essentially personal, and some can only be described as bad. The fact, however, that voluntary action is inspired by an unworthy motive does not necessarily make that action less effective than it would be if inspired by a good motive ; indeed, a person who gives voluntary service because of some personal aim or ambition has a strong incentive to efficiency. Human behaviour is often influenced by more than one motive, and sometimes by a mixture of good and bad motives. Moreoever, a person influenced by a good motive in an initial impulse to give voluntary service may continue to give such service for other and less worthy reasons. There is no clear pattern and therefore no easy analysis.

The highest motives seem to us to be common to all forms of voluntary service. Humanitarian idealism—the sense of duty towards one's neighbour—is the inspiration behind much devoted voluntary action. In its purest form it is entirely disinterested,

and there is no thought of reward, even of ultimate reward. It is an embodiment of the ideal of service to one's fellow men. It may take expression in a burning zeal for social reform and the unwearying struggle for what in the society of the time is a minority view, or it may simply express itself in personal service in however humble a capacity. Not far removed from this is a highly-developed sense of citizenship and of personal obligation to the community of which one is a member. Some people inherit a tradition of such public service and feel it their duty to continue a tradition of which they are proud, even if it involves personal sacrifice.

Some people give voluntary service because they are genuinely interested in the work to be done and wish to develop their interest, and others because it provides them with an opportunity for the practice of skills ; a person who enjoys organising will seek an opportunity to organise something.

We believe that in many cases there are essentially personal motives largely unrelated to the giving of voluntary service. Probably the most common of these is a desire for personal and social significance that is unsatisfied in private life ; the desire to feel of use to someone is one of the strongest of human desires. Voluntary service can provide companionship for the lonely, activity for the unoccupied, and an outlet for unused energy. It may also provide a means of escape from personal problems or conflicts. It is arguable that, apart from the value of the service given, voluntary service is of indirect benefit to the community in providing a means of working out personal conflicts and unhappiness.

Unfortunately voluntary service also provides opportunities for the fulfilment of other and less worthy desires. Committee service is a promising field for the "careerist" who seeks to be in the public eye and hopes for rewards and honours. Membership of a council, a board or a committee has to some people a high "prestige-value," and is a means of increasing their sense of personal importance, while the risk of personal failure is largely covered by collective responsibility.

Some kinds of voluntary service provide, or seem to provide, a means of "social-climbing," bringing direct contacts through a common purpose between people of widely differing background. In reverse they may be said to provide opportunities for patronage. They certainly can provide a stage for the exhibitionist and sometimes a satisfaction for the curious and inquisitive.

The desire to safeguard professional or sectional interests is perhaps a reasonable motive, but where personal profit or business advantage is involved it becomes less defensible. Where actual corruption is involved it becomes despicable ; this may range from petty malpractices, such as making personal profit on expenses claims, to the use of position or influence to secure favourable contracts.

We are inclined to think that the most vicious motive is the desire for personal power and the exercise of domination over other people. The desire for power is present in many people to a greater or lesser degree, and it is particularly dangerous when combined with a feeling of inferiority or insecurity. Contemporary society has extended the field of opportunity by weakening the formerly rigid class structure, reducing the chances of acquiring wealth, and creating increasing bureaucracy ; indeed it is arguable that a new form of currency, the currency of personal power, is coming into use. People whose opportunities for domination of others are limited in their home life and in their work can find opportunities in committee work and in voluntary organisations. Anything that offers the chance of satisfying the desire for personal power without the necessity

of accepting personal responsibility is particularly attractive. We do not suggest that there are more than a few such people serving on committees or working with voluntary organisations, but, since the influence of a forceful "power-seeker" tends to be considerable, we believe that even a few may do much harm to voluntary service and to the purpose that it serves.

We live in a world of changing values as well as changing social structures, and we believe that in considering the future of voluntary service we must take account of the first as well as the second. We must be realistic and recognise that voluntary service is not always inspired by the highest motives and undertaken in a spirit of idealism—it is perhaps too much to expect that this field of activity should be free from the effects of a growing materialism in society generally. We think that in some forms of voluntary service, in particular committee service, the results are not true criteria of the underlying motives, and that, with reasonable safeguards against the more serious forms of abuse, we need take no great account of motives. On the other hand we believe that in personal service the unworthy motive cannot fail to affect the service given, and that the true spirit of service is an important factor. In our view all possible steps should be taken by those who lead voluntary endeavour to build up an idealist philosophy for voluntary service of all kinds, a philosophy which will challenge the materialism so prevalent in our time.

CHAPTER II

THE HISTORICAL BACKGROUND

Contemporary social problems cannot be seen in true perspective unless they are seen against the background of history. A long sequence of cause and effect has shaped our social patterns and conditioned men's minds and opinions. The planning of our time has its origins in the past, and the concepts of our time will contribute to the shaping of new concepts in the years ahead.

Voluntary service given to hospitals has a long and honourable history. From mediaeval times to the present day there is an unbroken record of service in the care of the sick, and even a brief outline of this record, such as is given in this chapter, shows that what may seem to be revolutionary changes in our time are in fact part of an evolutionary process with its roots in the past. The process will continue, and the patterns shaped in our time will give place to new patterns, yet running through this history there is a continuous thread, which seems to resist all change—the instinct of man to help his fellow-men in time of need.

The Mediaeval Hospitals

The care of the sick was hallowed by religion in the nations of antiquity. In England the custom of hospitality was strengthened by the spread of Christianity after the landing of St. Augustine in 597 A.D. Men learned to care for the sick as part of their duty to God, and to the convention of mutual help was added the spirit of compassion. With the increase in pilgrimages the Church found it necessary to make provision for sick and

weary pilgrims. Hospitals were founded for this purpose, but they were primarily places of shelter rather than cure, since it was commonly believed that sickness was caused by sin.

The Norman period was one of great building activity. Hospitals were attached to abbeys and monasteries, and some were associated with shrines—notably St. Bartholomew's, Canterbury and Walsingham. Travel had increased and pilgrims from the East brought with them new diseases. Hospitals, although often endowed by wealthy laymen, were usually controlled, or at least influenced, by the Church. Not only was the care of the poor and sick a Christian duty, but the Church presided over all disbursement of alms and benevolences. Religious orders worked among the sick and poor, particularly in the towns.

During the five or six centuries leading to the dissolution of the monasteries in Tudor times more than 800 hospitals were founded. Financial support was provided by private benefactors and by the Guilds, whose philanthropy extended beyond their own brotherhood. Legacies were a profitable source of income, and mediaeval religious thought encouraged charity as atonement. Almsgiving was considered a noble virtue and each man of social standing had his almoner. Almoners of monasteries not only dispensed alms to travellers, beggars and lepers, but also visited in their homes the old and infirm and the lame and blind who were bed-ridden.

The fourteenth century was a period of prosperity in trade and industry and witnessed the growth of a wealthy middle class. Duty to the community was a recognised obligation and men were not allowed to shirk their civic responsibilities. For the most part religion was the strongest influence in good works. Philanthrophy tended, however, to treat the symptoms of distress rather than the causes; the poor were pitied, but poverty was accepted as an inevitable part of the ordained structure of society.

In the fifteenth century changes in religious thought and in the attitude to poverty and charity produced a reaction from mediaeval philanthropy. Private philanthropy, which had been weakened by corruption and abuse, declined and civic responsibility for poor relief increased. Sir John Oldcastle, one of the last of the Lollard leaders, promoted a Bill in 1414, although unsuccessfully, to provide for State foundation and endowment of hospitals which were to be under public administration. The century saw the decay of many hospitals brought about not only by maladministration but by the decay and depopulation of towns and villages.

The dissolution of the monasteries by Henry VIII caused the destruction of many hospitals, but some survived although their religious associations weakened. St. Bartholomew's and St. Thomas's Hospitals were refounded and were administered by citizens of London in a voluntary capacity. During the sixteenth century the hospitals became independent of the Church and responsibility for them was taken by the laity.

The changing economic structure and the increasing population intensified the problem of vagrancy, and by the latter half of the century it reached alarming proportions. A succession of Poor Laws endeavoured to supplement voluntary endeavour, and in 1572 a compulsory levy was ordered. This intensification of the problem of poverty helped to bring into being something in the nature of a "Welfare State" under the stringent control of the Crown. The Poor Law of 1601 established the principle of public responsibility and formed the basis of Poor Law administration until the nineteenth century. Private enterprise nevertheless survived, and many almshouses that still exist bear witness to it.

The seventeenth century provided many examples of charitable works, but hospital development was retarded: indeed, until the eighteenth century there were no important hospitals for sick people in London except St. Bartholomew's and St. Thomas's and, except in the capital, general hospitals scarcely existed. The hospital provision was quite unable to meet emergencies such as the plague, and the sick died in their homes.

The Voluntary Hospital Movement

By the eighteenth century, the century which saw the rise of the voluntary hospitals, the exercise of civic obligation to the sick poor had declined, yet this was a time when disease and sickness were presenting growing problems. Politically it was an age of *laissez-faire*: in private endeavour it was an age of activity. The doctrine of individualism gained ground and there was a lively spirit of enquiry; questions of science, theology and politics were discussed in the coffee-houses and salons. England was prosperous at home and victorious overseas, the Protestant Succession was assured, and the supremacy of Parliament was unchallenged. Men felt free to set their minds and energies to the task of building up trade and industry at home and overseas. In such an atmosphere it was natural that charitable endeavour should flourish. Schools, orphanages, foundling-hospitals and institutions for the blind, deaf and dumb were built and endowed. The Church was active in philanthropic work, and the Quakers were zealous in social endeavour. It was an age of humanitarianism influenced particularly by the political philosophies of Locke and later of Rousseau.

This was the background to the voluntary hospital movement. The need for hospital accommodation was overwhelming, and increased with the growth of the urban population in the new manufacturing towns. As always, Christianity was a powerful influence in promoting the care of the sick, but stimulus also came from the doctors. The development of medical knowledge and scientific enquiry was considerable, and the establishment of voluntary hospitals provided the physicians and surgeons with the opportunity of gaining experience by giving their services in the treatment of the sick poor. The Royal College of Physicians actively supported this policy, and in Scotland the money to found the Edinburgh Royal Infirmary was raised by the medical profession.

In the early part of the century Thomas Guy, a merchant, founded Guy's Hospital for the care of the incurable sick who were refused admission to the general hospitals. His example was widely followed by other men of wealth and position, but much money came from less wealthy subscribers, and the century saw the foundation of the Westminster Hospital in 1720, the first hospital to be founded without an endowment and to be dependent on voluntary contributions. The hospitals were administered by voluntary Boards of Governors, a pattern which continued to the present century.

The religious influence on philanthropy in the founding of hospitals is well shown by this inscription which was placed over the doorway of the first Liverpool Royal Infirmary:

"O ye whose Hours exempt from sorrow flow,
Behold the Seat of Pain, Disease and Woe,
Think while your hand th'entreated Alms extend
That what to Us ye give to God ye lend."

The Nineteenth Century—a Century of Progress

On reaching the nineteenth century it becomes difficult to follow the developments in connected sequence. The pattern of society had become more complex. The treatment of the sick poor and the care of the poor had separated into distinct paths. The development of the voluntary hospital must be traced separately from the developments in Poor Law administration which led ultimately to the establishment of municipal hospitals, and both must be seen against the background of social thought and political change.

The nineteenth century inherited from the eighteenth century a new attitude to charity. The teaching of Rousseau had influenced a development of thought which, inspired by humanism rather than by religion, took expression in a desire to relieve distress. "Man is born free," he wrote, "yet everywhere he is in chains." Jeremy Bentham, James Mill, Robert Owen, John Stuart Mill and others of their time became the nineteenth century apostles of humanism. Side by side with this was the influence of the Evangelical Revival which stimulated private philanthropy. The upper and middle classes began to see the squalor and distress as a social and religious obligation. The pioneer reformers translated charity into action.

The Reform Bill of 1832 ushered in a new political era, and the century was marked by important social legislation. In the field of health the fear of cholera acted as a spur. By the middle of the century the policy of *laissez-faire* was on the decline. The public social conscience had been aroused and the needs were seen. It was the method of meeting the needs which was the subject of controversy. The philanthropists, supported by the Charity Organisation Society, stood for "self-help" and "voluntaryism"; the Radicals advocated increasing State aid. Gladstone's budget of 1863 raised a storm of protest over his proposal to tax charities, including legacies, a proposal which he was compelled to withdraw as a result of influential opposition. "Voluntaryism" maintained its position, but a policy of State provision and control was beginning to emerge.

The building of hospitals on the eighteenth century model continued in the nineteenth century. The development of these voluntary hospitals can best be seen by tracing the history of those which have become the great hospitals of our time. In this period it is a record of personal charity and devotion, and of improvement in medical science, hospital conditions, nursing and administration.

The hospitals of a hundred years ago were very different from those of our time. They were overcrowded, dirty and insanitary, the food was bad, and heating, lighting and ventilation were inadequate : indeed it has been said that as many patients died as a result of bad conditions in the hospitals as died of the diseases from which they suffered on admission. Nursing was a profession for women of the lowest type, and the hospitals were notorious for drunkenness and immorality. The century, however, saw the hospitals revolutionised by the inspiration of Florence Nightingale, who, inspired by a Christian call to serve the sick, set new standards for hospital accommodation, created the nursing profession as one of the leading professions for women, and worked out rules and procedure for hospital administration which formed the basis of the present system.

In the latter half of the century many cottage hospitals were founded as charities for the benefit of the sick poor in the country districts. In the towns specialist hospitals, such as the Royal London Ophthalmic Hospital, the Royal National Orthopaedic Hospital, the Cancer Hospital and the Royal Hospital for Incurables were established. The

long process of change in the functions of the hospital from the place of shelter in the mediaeval hospice to the place of specialised healing was almost complete.

The latter part of the century saw a great advance in medical and scientific knowledge which revolutionised both medicine and surgery. As the hospitals and medical treatment improved the demand increased and the hospitals ceased to have only the poor as their patients. Expansion brought with it financial difficulties and new methods had to be devised to increase income. By the end of the century wards for paying patients had been opened by some hospitals. In some of the larger towns Hospital Saturday Funds and Hospital Sunday Funds were started. Even so the financial position of many of the hospitals had become serious.

Social development is never free from opposition. In the latter part of the nineteenth century there were vigorous attacks on the voluntary hospitals. The Charity Organisation Society, founded in 1869, charged them with being indiscriminating purveyors of charity, helping people who could afford to help themselves. The system of admissions was criticised, it being alleged that undue influence was exercised by the larger subscribers in favour of their nominees. These attacks proved, however, to be constructive since they led ultimately to the creation by the Society of the profession of hospital almoner which, although its functions have somewhat altered, makes a valuable contribution to the hospitals of to-day. The Society also criticised "the arbitrary and irresponsible power of the governing bodies" and advocated centralised control in the London area, although it also opposed the provision of hospitals by the State. This was strongly resisted by the voluntary hospitals of London, and their resistance met with success. Sir Henry Burdett, who played an active part in the controversy, promoted in 1897 what later became King Edward's Hospital Fund for London, and this new organisation began to exercise a co-ordinating influence. The voluntary hospitals survived all this opposition, and by the end of the century they had become much as we have known them in our time, although provision was still on a limited scale and many improvements were needed.

Meanwhile there were significant developments in the treatment of the destitute sick under the Poor Law administration. In the first half of the century the destitute sick were cared for in sick wards in the workhouses. Those who were not destitute could obtain treatment, as a substitute for hospital attendance, in public dispensaries, the first of which had been provided at the end of the eighteenth century as an alternative to ill-administered medical relief. The political mood in the early years of the century encouraged self-help, and among the poorer classes there existed a remarkable spirit of independence. The working-classes turned to the Trade Unions and Friendly Societies* for security and attempted to meet the risk of poverty through sickness by Provident Insurance. After 1840 the Provident Dispensary was introduced, and this began to provide for the poor man something like the service of a family doctor. Despite competition from the Medical Aid Association, a profit-making concern, and the out-patient departments of the hospitals, both of which sought to attract patients to their lists, the Provident Dispensaries flourished, and by the end of the century were giving treatment to a large number of people.

Provident Insurance was, of course, only within reach of the "respectable artisan"; the lower working-classes were left to the Poor Law. In 1867 an Act of Parliament, establishing a new Poor Law Hospital Authority in London, stimulated the reform of

*Lord Beveridge has given a full account of the development of the Friendly Societies in his report entitled "Voluntary Action" (1948).

the few existing poor law infirmaries and led to the increased establishment of further separate infirmaries in which the destitute sick could be treated. These were maintained by the Boards of Guardians continuously until 1929 when the Boards were abolished and their powers and duties were transferred to County and Borough Councils. The new infirmaries were, however, in many cases little more than an extension of the sick-wards of the workhouses, and, since they attracted a social "stigma," it was natural that the poor man who became ill endeavoured to get admission to a voluntary hospital and regarded the infirmary as the last resort.

The Public Health Act of 1875 gave power to Local Authorities to provide general hospitals, but the powers were not used until 1918, and then only by three Authorities. The Local Authorities were concentrating on the provision of hospitals for infectious diseases and mental hospitals. Asylums had been provided early in the century, not as places where mental illness was cured but as places of detention. The Lunacy Act of 1890 opened the door to new developments, and resulted in the extension of mental hospitals, but it was more than 20 years before there was to be a significent advance in this field.

The reign of Queen Victoria saw great social progress, a great advance in medical and scientific knowledge, a transformation of the hospitals, the creation of the nursing profession, and significant developments in the care of the poor who were sick. It also heralded a new kind of political and social thought which, hardened in the fires of war, became a social revolution.

The Last Fifty Years—A Time of Transition

At the opening of this century hospital accommodation and treatment for the acute sick was provided almost entirely by the voluntary hospitals, while the Local Authorities provided mental hospitals, infectious diseases hospitals and infirmaries. More hospital beds were needed, and the first years of the century up to the outbreak of war in 1914 were a period of expansion and, as a result, of increasing financial difficulties. By 1914 the voluntary hospitals had substantially increased both their accommodation and their deficits.

During the 1914-1918 war the civilian hospitals played their part by providing beds and treatment for the military casualties which came in a steady stream across the Channel. Payments made for these services were not, however, sufficient to offset the rapidly rising costs. Not only were there large increases in the cost of all hospital equipment, and of drugs and dressings, but salaries and wages were rising. By 1918 the position was serious. Relief was provided by substantial grants from the National Relief Fund, King Edward's Hospital Fund for London, the Red Cross and St. John Ambulance Fund, but these grants, while meeting immediate deficits, did not provide a permanent solution to the problem.

In 1919 Parliament appointed a Minister of Health, and in 1921 the Minister appointed a Voluntary Hospitals Committee, under the chairmanship of Lord Cave, to consider what steps should be taken. This Committee found that, whereas the ordinary income of the voluntary hospitals in the London area had risen since 1913 by 67 per cent., the ordinary expenditure had risen over the same period by 138 per cent., a position which was reflected in the provinces to a considerable extent; that the voluntary hospitals were together facing a deficit of over one million pounds; and that there was need for new accommodation which would cost over four million pounds.

The Cave Committee was convinced that the voluntary hospitals should be saved—"The voluntary hospital system, which is peculiar to the English-speaking peoples, is part of the heritage of our generation ; and it would be lamentable if by our apathy or folly it were suffered to fall into ruin." It was equally concerned that nothing that was done should undermine the voluntary principle—"If the voluntary system is worth saving, any proposals for continuous rate or State aid should be rejected." It recommended that Parliament should sanction a temporary grant of one million pounds, and that this should be expended under the direction of a Hospitals Commission on the lines of the University Grants Committee. It also recommended that Voluntary Hospitals Committees, appointed by the Lord Lieutenants with the help of the Mayors and Chairmen of County Councils, should be set up throughout the country, to cover the areas of the major Local Authorities, to advise the Hospitals Commission on the amount of aid required in their areas, and, since they were concerned at the "present lack of organisation and co-operation among the voluntary hospitals," to take all possible steps to secure co-ordination by agreement with the hospitals concerned.

Parliament sanctioned a temporary grant of only £500,000, and made the grants to individual hospitals conditional on an equal sum being raised from voluntary sources. Over 40 Voluntary Hospitals Committees were set up, but they became relatively ineffective after the grants had been distributed. The Sankey Committee's Report of 1937, to which reference will be made later, gave the following verdict :

> "Both the Voluntary Hospitals Commission and the Voluntary Hospitals Committees were set up and continued to function for some time after the distribution of the grant of £500,000 made to them by Parliament. They failed, however, to bring about those reforms in the voluntary system which the Cave Committee urged as so necessary for its efficiency, and they gradually ceased to function, not necessarily because their distributable funds came to an end, but because, owing possibly to their method of appointment, they never secured the whole-hearted support of the hospitals themselves. They failed also because in 1921 the efficiency of the voluntary hospitals as a system, and not their individual existence, was at stake, because opinions as to reform differed, and because there was no external menace to drive them together."

Finance continued to be the central problem. In 1925 the Voluntary Hospitals Commission reported that there appeared to be a need for at least 10,000 more beds, and recommended that there should be government grants of 50 per cent. of the cost up to a maximum of £200 per bed. In making this recommendation the Commission wrote :

> "We are, therefore, forced, however reluctantly, to the conclusion that a substantial measure of State assistance is essential to enable voluntary hospitals to overtake the arrears which have accumulated in the last ten years. In suggesting a grant towards capital expenditure on expansions we are anxious to avoid anything which might tend to render voluntary hospitals less dependent on voluntary support and more dependent upon Government subsidies than they are at present. We recognise that any Government grant is to a certain extent dangerous to the voluntary principle, and should be given sparingly and subject to stringent conditions."

Government grants were not made, but Local Authorities were empowered to make direct grants to voluntary hospitals and to levy up to 1.1/3d. rate for this purpose: in some cases these powers were used. New sources of income were found. Accommodation for private paying patients was increased, and patients in the public wards were expected to contribute what they could afford. The greatest new sources of income were, however, the Contributory Schemes which, on the experience of the pioneer schemes, the Cave Committee had strongly advocated. There were great developments in Contributory Schemes between 1929 and 1934, and by 1948 there were said to be 10 million members, the schemes covering 22 million adults and children. Indeed by 1948, through these Contributory Schemes, working men and women were making a substantial contribution to the voluntary hospitals.

Meanwhile there were developments in the municipal field. Just as the voluntary hospitals were taking patients who could not be described as poor, the infirmaries were beginning to take patients who could not be classified as destitute, a fact that was noted by the Royal Commission on the Poor Law in 1909, and, as the voluntary hospitals could not provide all the beds that were needed, more and more the infirmaries filled the gap. Their standards improved and the Poor Law stigma was weakening. The swing to Liberalism early in the century resulted in Lloyd George's National Insurance Act of 1911, which, through the "panel" system, gave the working-classes the chance of the services of the general practitioner. The Act also stimulated the development of tuberculosis clinics and sanatoria by including treatment for tuberculosis as an insurance benefit and by providing capital grants for sanatoria. The war of 1914-1918 held up building developments but acted as a stimulus for future development by exposing social needs. In 1919 the Local Authorities were empowered by the Maternity and Child Welfare Act to provide maternity homes and hospitals. In 1921 the Public Health (Tuberculosis) Act gave the major Local Authorities the duty of extending their tuberculosis services. The Education Acts of 1918 and 1921 provided for the development of the school medical services.

A great advance was made also in the field of mental health. Departments of psychiatry and neurology were established in some of the larger voluntary hospitals and in 1923 the London County Council opened the Maudsley Hospital for the treatment of voluntary patients. In 1925 a Royal Commission on Lunacy and Mental Disorders was set up, and its Report in 1926 reflected a new concept of mental illness which had become accepted as a result of pioneer endeavour in which voluntary societies played a leading part. This led to the Mental Treatment Act of 1930 which replaced the old "asylums" by "mental hospitals" which were required to take voluntary patients as well as patients who were certified. The Act also stimulated the provision of psychiatric clinics.

These developments, together with the changing political and social thought, led to the Local Government Act of 1929 which abolished the Boards of Guardians and transferred their powers and duties to the County and County Borough Councils. This was the first real step towards the abolition of the Poor Law which had lasted from Elizabethan times: what remained was now called "Public Assistance." The Act also gave the Local Authorities the power, but not the duty, to provide general hospitals by providing new buildings or by using the infirmaries, and enabled them to make contractual arrangements with voluntary hospitals. The great significance of this Act is that it marked the acceptance of public responsibility for the provision of hospitals, and created the municipal hospitals as potential rivals to the voluntary hospitals. It was an important step towards a national hospital service.

The entry of the State, through the Local Authorities, into the field of hospital provision caused the voluntary hospitals to take stock of their position. In Liverpool, Manchester, Sheffield and Oxford the principal voluntary hospitals united under joint administrations. In 1935 the British Hospitals Association set up a Voluntary Hospitals Commission, under the chairmanship of Lord Sankey, "to take into consideration the present position of the voluntary hospitals of the country ; to enquire whether in view of recent legislative and social developments it is desirable that any steps should be taken to promote their interests, develop their policy and safeguard their future, and to frame such recommendations as may be thought expedient and acceptable." The Commission issued a report in 1937. This referred to the report of the Cave Committee of 1921 and stated: "The stimulus of immediate danger to their existence which was absent in 1921 has been supplied by the passing of the Local Government Act of 1929 and the advent of the council hospital. To-day the voluntary hospitals are themselves demanding those very reforms which the Cave Committee urged upon them and which they neglected to carry out." The Committee recommended that the voluntary hospitals should set up regional councils to co-ordinate the work of the hospitals in each region, and that the work of the regional councils should be co-ordinated by a central council. It accepted the fact that hospitals generally would be unwilling to hand over their funds to a central pool, and therefore recommended as a first step the creation of regional funds "on a basis similar to that of King Edward's Hospital Fund for London."

Although an important step was taken by the foundation in 1939 of the Nuffield Provincial Hospitals Trust, which aimed at the co-ordination of hospitals outside London, further development was interrupted by the outbreak of war. In the previous ten years some new municipal hospitals had been built, but only some of the Local Authorities had made any progress in providing hospitals, or had exercised their powers of appropriating the infirmaries. Hospital accommodation was still inadequate, and many of the infirmaries remained as before under Public Assistance administration. Even so, more than one-half of the hospitals in the country, with more than two-thirds of the beds, were now controlled by the Local Authorities.

The position in 1939, when the Ministry of Health faced new war-time responsibilities, has been frankly stated by R. M. Titmuss in his "Problems of Social Policy" in the official "History of the Second World War," as follows :

> "The Ministry faced a rigid and conservative social institution. First, on the one hand, there existed a multiplicity of individualistic voluntary hospitals ranging from the great teaching hospitals to the small, debt-ridden institutions sometimes over-proud of their operating theatres, but often short of surgical specialists. Secondly, on the other hand, there were the local authority hospitals, tied to worn-out boundaries, receivers of all the unwanted and uninteresting chronic cases, still flavoured with the stigma of the Poor Law, and often badly equipped and accommodated in large prison-like buildings. Somehow the Ministry had to bring together these rival systems, and to create, out of the varying and independently provided hospital facilities, a national organisation for the care and treatment of air-raid casualties."

Plans for the Emergency Hospital Service, which were made before the war, were based on the assumption that casualties in air-raids would be several times as great as they proved to be, even in the height of the attack on London. Hospitals were to be cleared as far as possible of ordinary patients, and were given functions appropriate to

their accommodation, equipment and geographical position : the plan for London was based on separately controlled segments with the centres in the heart of London and stretching out into the country, a pattern which was the forerunner of the present Metropolitan hospital regions. The voluntary hospitals were to remain under their independent management, but were to reserve for the Emergency Hospital Service an agreed number of beds for which payment would be made from government funds : the municipal hospitals were to work on the same arrangements as far as possible bearing in mind their legal obligation to admit patients.

At the outbreak of war 140,000 patients were cleared out of the hospitals, leaving empty beds in anticipation of air-raids which were not experienced for a further year. Additional beds were provided in "hutted" extensions, new equipment was supplied, and as time went on the standard of hospital accommodation steadily improved. Gradually it came to be appreciated that the hospitals were able to care for their ordinary patients, at least for the seriously ill, as well as for service patients and air-raid casualties. Titmuss writes : "In theory, at least, there were now two hospital services in England and Wales superimposed on two hospital systems ; one service for special war-time purposes and another for the ordinary sick."

The financial position of the voluntary hospitals improved during the war and in many hospitals deficits gave place to substantial surpluses. To balance this, however, many hospitals suffered from bomb-damage, and much building that would have been done in peace-time had to be postponed for the duration of the war.

The experience of the Emergency Hospital Service in war-time showed that a national hospital service could be run effectively, and this, as will be shown in the next chapter, was one of the last of a series of steps which led to the establishment of the hospital service as it exists to-day.

CHAPTER III

THE NEW HOSPITAL SERVICE

(a) Developments leading to a National Hospital Service

The brief survey of hospital history given in the last chapter may be said to cover four stages of development. In the first stage the voluntary hospitals were the only hospitals in existence ; in the second the Poor Law became responsible for treating the destitute sick ; in the third the Local Authorities began to establish municipal hospitals providing general hospital services ; in the fourth the two systems were compelled by the needs of war-time to work together, at least to a considerable extent, under central direction. Since some of the difficulties which have arisen in the new hospital service are legacies of the past, it is important to examine rather more closely the steps which led finally to the creation of a national service in its present pattern.

As will have been seen, ever since the latter part of the 19th century there has been a struggle between two opposing schools of thought, between the upholders of "voluntary-ism" and independence on the one hand, and the advocates of State aid and State provision on the other.

In 1920 the Consultative Council, under the chairmanship of Lord Dawson of Penn, submitted a report to the Minister of Health on the future provision of medical and allied services. This report included a scheme for a national health service based on primary and secondary health centres and for the first time introduced the concept of planning a hospital service on a regional basis, with administration undertaken by a new health authority to consist partly of elected members and partly of nominated members. In 1921 the Cave Committee, doubtless influenced by the Dawson report, vigorously defended "voluntaryism," and reported as follows :

> "It has been suggested by some, but a very small minority, of the witnesses that liability for the hospitals should be taken over by the State or thrown upon the rates, or at least that a regular yearly grant-in-aid should be made from one of those sources. In our view either proposal would be fatal to the voluntary system. If it is once admitted that there is an obligation either on the State or on the Local Authorities to make good deficits, hospitals will have lost their incentive to collect and subscribers their inducement to contribute. A limited grant-in-aid, if proportional either to voluntary subscriptions or to the cost of beds occupied, might not so swiftly have that effect ; but it would be the beginning of the end, and not many years would pass before the hospitals would be "provided" out of public funds. Further, any yearly grant-in-aid would presumably be made to all hospitals alike, including those which are able to pay their way and require no such assistance ; and this would involve a waste of public money which should by all means be avoided. If the voluntary system is worth saving, any proposals for continuous rate or State aid should be rejected. Is the voluntary system worth saving ? We are convinced that it is."

The Cave Committee saw that the greatest danger to the voluntary hospitals was their failure to work together in a co-ordinated scheme, but, as has been shown, their warnings were not heeded, and when the Local Government Act of 1929 brought into existence a rival system of public hospitals the voluntary hospitals were as individualistic and disunited as ever.

Undoubtedly informed public opinion was moving in the direction of a national service. The Sankey Committee made an attempt to preserve the voluntary system by recommending the organisation of all voluntary hospitals in a single association to work side by side and in co-operation with the municipal hospital organisation. They reported as follows :

> "There are, no doubt, some who would prefer the voluntary system to be the only hospital system. Equally, no doubt, there are some who would prefer a public authority system to be the only system, but it is clear to us that for many years to come it would be an advantage to the community for both systems to exist side by side, as they have much to learn from one another and any violent change-over from one system to the other could not result in anything but grievous harm to the community."

The warning was conveyed to the hospitals in the strongest terms :

> "The Commission therefore conclude this General Survey with an emphatic

expression of their opinion that the continued existence of the voluntary system depends upon the voluntary hospitals of the country forming themselves into an association, regionally organised, which would be able on all matters of policy to express the considered views of its members and rely upon their loyal acceptance of its decisions."

The report produced few immediate results. There were some schemes of local co-operation between voluntary hospitals and municipal hospitals, but the most important development was the establishment in 1939 of the Nuffield Provincial Hospitals Trust which included among its aims the co-ordination of hospitals on a regional basis on the lines of the co-ordination in London achieved by King Edward's Hospital Fund.

In 1938 the British Medical Association issued a report entitled "A General Medical Service for the Nation." This report set out a plan for a comprehensive health service administered largely by those Local Authorities with a population of not less than 75,000 to 100,000. The plan provided for the hospital service to be organised on a regional basis by co-operation between the voluntary hospitals and the municipal hospitals, and administered by joint boards of the Local Authorities with strong medical representation.

The war brought to the hospitals the experience of working together in the Emergency Hospital Service; as Titmuss writes:

> "It demonstrated, in its limited field, what a hospital service could be, and it gave many institutions of varying character and type their first real opportunity to work together for a common purpose . . . The demands of war were inescapable, but, once accepted, they produced ideas as relevant to the needs of peace as of war."

The planning of the Emergency Hospital Service was made exceptionally difficult by the lack of statistical and other information about the hospitals, so in 1938 the Minister of Health arranged for a complete survey of all hospitals in the country to be undertaken by experienced medical officers. Further surveys were undertaken after 1941 by the Ministry of Health in conjunction with the Nuffield Provincial Hospitals Trust, and the survey reports, which were eventually published in 1945, produced information of great value. The reports showed that the hospital facilities available were far from satisfactory, and produced the following conclusion: "The general conclusion to be drawn from all this evidence can only be that either in quantity or quality deficiencies in all types of accommodation were widespread in 1938." As to quantity, it has been estimated that on any given day in 1938-1939 there were not less than 100,000 people waiting to be admitted to voluntary hospitals. As to quality, in August 1939 the Director-General of the Emergency Medical Service wrote:

> "Prior to the repeated surveys which have been made by the Ministry of Health during the past eighteen months there was little appreciation of the low standard of hospital accommodation in the country as a whole. Even those centres of enlightened treatment and teaching in our large cities are, with few exceptions, structurally either unsafe or woefully antiquated."

As Ives has stated in his "British Hospitals": "The cost of the reforms needed would be on a scale which could only be found from the Exchequer."

As early as 1941 the first indication was given of the Government's post-war hospital policy. On October 9th, 1941, the following statement was made by the Minister of Health in the House of Commons :

> "It is the objective of the Government as soon as may be after the war to ensure that by means of a comprehensive hospital service appropriate treatment shall be readily available to every person in need of it. It is accordingly proposed to lay on the major Local Authorities the duty of securing, in close co-operation with the voluntary agencies engaged in the same field, the provision of such a service by placing on a more regular footing the partnership between the Local Authorities and voluntary hospitals on which the present hospital services depend. The Government recognise that to achieve the best results and to avoid a wasteful multiplication of accommodation and equipment it will be necessary to design such a service by reference to areas substantially larger than those of individual Local Authorities. It will be the aim of the Government also to avoid overlapping and uneconomical expenditure by securing the provision of the more highly specialised services at teaching hospitals and other centres selected to serve these wider areas, and by arranging for a proper division of function between hospitals in these areas.
>
> With regard to the financial aspects of the Government's proposals, it is their intention to maintain the principle that in general patients should be called on to make a reasonable payment towards the cost, whether through contributory schemes or otherwise. In so far as any new burden may be thrown upon Local Authorities in providing or maintaining hospital accommodation, or in contributing towards the expenditure of voluntary hospitals, a financial contribution, the extent of which will be a matter for further consideration, will be made available from the Exchequer. Special arrangements for dealing with the teaching hospitals by way of increased educational grants are in contemplation."

In December, 1942, the Beveridge Report was published. Under the plan for "social security" recommended in this report it was stated that "medical treatment covering all requirements will be provided for all citizens by a national health service organised under the health departments . . . ", and the plan was to cover "all citizens without upper income limit."

In February, 1944, the Minister of Health of the Coalition Government, the Rt. Hon. H. U. Willink, issued a White Paper entitled "A National Health Service" setting out in detail the Government's policy which, after discussion by the House of Commons, would be embodied in a Bill. The Government's proposals were in line with the plans of the British Medical Association. It was recognised that the administrative areas for the hospital service should be larger than those of the individual Local Authorities, and it was proposed that the service should be organised on a regional basis and administered by joint boards of the major Local Authorities. The joint boards were to take over the municipal hospitals, and were to be empowered to make contractual arrangements with the voluntary hospitals in their areas on a basis of payment for services rendered. The voluntary hospitals were to retain their independence, but were to be an integral part of the new hospital service. Technical advice to the joint boards, which would consist largely of laymen, was to be provided by the establishment of Local Health Services Councils ; this was considered to be preferable to providing direct professional repre-

sentation on the joint boards since it would not risk "impairing the principle of public responsibility—that effective decisions on policy must lie entirely with elected representatives answerable to the people for the decisions that they make."

The services for which the Local Authorities were responsible, e.g., the public health, maternity and child welfare, and tuberculosis services, were to remain their responsibility, but were to conform to the area health service plans of the joint boards, which would be the planning authorities. The general practitioners would continue to work independent practices, or to work in grouped practices, and would staff health centres to be provided by the Local Authorities in accordance with the joint boards' plans.

The cost of the new hospital service was to be met partly from rate funds and partly from Exchequer funds, the latter including such proportion of the social insurance contributions of the public as was attributable to hospitals. It was estimated that the whole of the health services would cost 132 million pounds a year, of which 48 million would be met from rate funds, a further 48 million from Exchequer funds and 36 million from social insurance contributions. The Exchequer contribution provided for a grant, estimated at 10 million pounds, to be made direct to the voluntary hospitals.

The White Paper was debated by Parliament, and there followed a series of consultations between the Ministry, the Local Authorities and the medical profession. However, before a Bill was presented to Parliament the war came to an end and the political scene changed. It fell to the Labour Government, and to the Rt. Hon. Aneurin Bevan as Minister of Health, to take the final step in creating the national hospital service.

(b) The National Health Service Act, 1946.

The Labour Government which came into power in 1945 speedily turned its attention to the planning of the health services. A Bill was published in March 1946 and presented to the House of Commons for its Second Reading on April 30th, 1946. By November it had passed both Houses of Parliament, and on November 6th it became the National Health Service Act, 1946.

The Act differed in certain important respects from the proposals submitted to the House of Commons two years before by the Coalition Government. The most fundamental differences, so far as the hospitals were concerned, were first that all except a few of the hospitals were to be taken over by the State, and secondly that the proposal that the health service should be administered by joint boards of the major Local Authorities was abandoned in favour of the creation of completely new administrative authorities for the hospital service and the general practitioner service. Thus the voluntary hospital system was virtually to disappear, and the Local Authorities were to have no further powers of providing and maintaining municipal hospitals.

Under Clause 1 of the Act the Minister of Health was given the duty "to promote the establishment in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness," and for that purpose to provide, or secure the effective provision of, appropriate services specified in the Act. This was the first time that the State, acting through its Minister, had taken such responsibility.

The premises of all hospitals, voluntary hospitals and municipal hospitals, were to be transferred to the Minister and their existing governing bodies were to be dissolved. The Minister was, however, given power to inform the governing body of a voluntary

hospital, or the Local Authority in the case of a municipal hospital, that a particular hospital was not required and need not therefore be transferred : in such circumstances the governing body or Local Authority had the right to inform the Minister that they desired their hospital to be transferred, and the Minister was bound to accede to such requests. Certain convalescent homes and other special types of institution were excluded from the service.

The endowment funds of hospitals designated as teaching hospitals were to remain under the control of their new governing bodies. The endowment funds of all other transferred hospitals were to be taken into a central pool—the Hospital Endowments Fund—and used for the benefit of all the non-teaching hospitals.

The Act provided for the hospital service to be administered by newly created hospital boards and committees. England and Wales were to be divided into regions, each region having within it a university medical school, and for each region there was to be appointed a Regional Hospital Board. Within the regions hospitals were to be allocated, in accordance with plans prepared by the Regional Hospital Boards, into conveniently administered groups, and the Boards were to appoint a Hospital Management Committee to administer each of these groups. The teaching hospitals were also to be grouped, and each teaching hospital group was to be administered by a Board of Governors.

The chairmen and members of the Regional Hospital Boards were to be directly appointed by the Minister, who was required before making the appointments of members to consult various bodies, including the Local Authorities, the representatives of the former voluntary hospitals, the universities and the medical profession. The chairmen and members of the Hospital Management Committees were to be directly appointed by the Regional Hospital Boards after similar consultations. The chairmen and members of the Boards of Governors of the teaching hospitals were to be appointed by the Minister after appropriate consultations, although provision was made for certain members to be appointed on the nomination of the universities, the medical and dental teaching staff, and the Regional Hospital Boards. Regulations made under the Act provided that all such appointments should be for a term of three years, the original appointments being adjusted so as to arrange from the start for the retirement each year of one-third of the members.

The hospital service was to be provided free of charge to the patients, although the individual citizen through social insurance contributions and taxation would in fact be paying a part of the cost. The cost of the service was to be met in full by Parliament, and arrangements were to be made by regulations to provide money to meet the expenses of the Regional Hospital Boards, the Hospital Management Committees and the Boards of Governors of teaching hospitals.

All employees of the hospital service were to be employees of the Regional Hospital Boards, and in teaching hospitals of the Boards of Governors, and the remuneration and conditions of service were, subject to regulations, to be determined by these bodies.

Hospitals were to be permitted to provide separate accommodation for private patients, who would be required to pay the full cost of treatment and maintenance up to an approved maximum, but such accommodation was to be made available for the use of non-paying patients on medical need or if other suitable accommodation was not available.

Part III of the Act provided for the Local Authorities to be responsible for the public

health service, for a number of allied services—maternity and child welfare, health visiting, home nursing, vaccination, immunisation, and the ambulance services. They were also to be responsible for the provision of home helps for people in need. The Act also gave the Local Authorities the duty of providing and equipping health centres to be used by general practitioners, dentists and pharmacists.

The general practitioner service was, however, to be administered by separate authorities, Executive Councils, which would be composed of members appointed by the major Local Authorities and the medical, dental and pharmaceutical professions, and a small number of members appointed by the Minister, including the chairmen.

The sale of practices was to be abolished, and the distribution of doctors was to become the responsibility of a Medical Practices Committee to be appointed by the Minister and to consist largely of medical practitioners.

It is interesting to compare the financial arrangements of the Coalition Government's proposals and the Labour Government's proposals. In the financial memorandum attached to the Bill it was estimated that the whole of the health services would cost £152 millions, of which £6 millions would be met from rate-funds, £110 millions from Exchequer funds and £36 millions from social insurance contributions and miscellaneous receipts. It will be seen that under the new scheme the liabilities on rate-funds were to be negligible—£6 millions as compared with £48 millions under the previous scheme : this was perhaps some compensation to the Local Authorities for losing control of the municipal hospitals.

In the debates on the Bill in the House of Commons high tributes were paid to the voluntary hospitals by the Minister of Health and by members on both sides of the House. Some attempt was made by the Opposition to preserve the independence of the voluntary hospitals, and, particularly, their right to retain their endowment funds, but it was widely recognised that the dependence of a major part of a national hospital service on private subscription would not be possible, especially in view of the high rate of taxation and the consequent decline in personal incomes. No substantial opposition came from the Local Authorities. There was strong opposition from the greater part of the medical profession to certain of the provisions of the Bill, in particular those governing private practice, and when the Bill became law it seemed possible for some time that the medical profession might be unwilling to take part in the service, but after protracted negotiations the opposition was eventually withdrawn.

It has already been mentioned that the Act provided that certain hospitals could be left outside the service. About 200 hospitals and homes were in fact "disclaimed" and have remained voluntary hospitals dependent, as in the past, on private subscription. Most of these hospitals and homes are either very small or connected with a religious denomination or order. Some of them play a part in the hospital service by contractual arrangements.

Throughout 1947 preparations were made for the new hospital service. The Regional Hospital Boards were constituted by an Order in Council dated June 24th and started to make preparations in their regions. The hospital groups were planned and the Hospital Management Committees were appointed. On July 5th, 1948, all hospitals, except the few disclaimed hospitals, were transferred to the Minister of Health and the new hospital service came into operation.

PART II

CHAPTER IV

VOLUNTARY SERVICE IN HOSPITAL ADMINISTRATION

(a) The Partnership of the State and Voluntary Service

In this country a very large number of men and women give voluntary service as members of committees. This is something that lies at the root of our democratic tradition. Committee administration may be cumbersome and slow, but it is an effective barrier to tyranny, not only the tyranny of totalitarianism but also the lesser tyranny of bureaucracy. The committees of this country—and there are many thousands of them —are democracy at work. This voluntary element in public administration has over many years proved that its strengths outweigh its weaknesses, and there are few who would not favour its preservation.

With the State entering more and more directly into fields of social service that have in the past been cultivated wholly or mainly by voluntary endeavour, we are faced with the problem of blending central direction with decentralised voluntary administration ; this blending may take various forms as new administrative patterns are devised. In its choice of an administration for the hospital service under the National Health Service Act of 1946, Parliament has embarked on a courageous and important experiment. The hospital service has been "nationalised," but its administration in the field has been entrusted to voluntary committees, each of which is given by the Act statutory responsibilities and corporate status. It is the first example in this country of a public service which is financed almost entirely from public funds being operated by a government department and voluntary service in partnership. The "freehold" is vested in Parliament, and the "leasehold" is entrusted to voluntary service. While maintaining that it is a courageous experiment, it is reasonable to claim that it is evolutionary rather than revolutionary. As is shown earlier in this report, the hospital service owes much to voluntary endeavour, and it is fitting that the great tradition of voluntary service for the hospitals has been perpetuated in the new system of administration.

It is our purpose in this chapter to examine this partnership at work. On the one hand we have tried to discover whether the administrative structure and the terms of the partnership are such as to encourage able men and women to give their time and energies to this kind of work without financial or other reward ; on the other hand we have tried to discover whether those who serve are giving their service in full measure and whether this is reflected in the efficiency of the hospital service. This task has led us to examine the hospital service in operation, since we believed that only through such an investigation would we reach valid conclusions.

It is not always appreciated that the transition in 1948, when the new scheme came into being, could hardly have been smooth since the new hospital service inherited two systems of administration based on entirely different principles. The administration of

the former voluntary hospitals differed in important respects from that of the former municipal hospitals.

The voluntary hospitals were administered by governing bodies in a position of independent control. Hospital policy was determined by the Governors acting on the advice of the hospitals' medical staff. Each hospital had its Medical Committee which was, as a general rule, composed of all the senior medical staff. In some hospitals certain members of the Medical Committee served also on the governing body; in others the advice of the medical staff was given to the lay members of the Governors through a joint committee. It was the normal practice of governing bodies to delegate considerable responsibilities to a small House Committee and to the hospital officers, and the detailed administration of the hospital was commonly entrusted to the House Governor, medical staff and Matron. Since, apart from payments made by, or on behalf of, patients, the voluntary hospitals were largely dependent on private subscription and legacies, the Governors were compelled to keep expenditure within the limits of available income, and it was accepted as a hospital tradition, initiated by Florence Nightingale, that a primary function of the administration was the enlightened pursuit of economy "so far as it is consistent with the requirements of the sick."

The municipal hospitals had since 1930 been administered by the Local Health Authorities, and their governing bodies were appointed by, and responsible to, these Authorities. They were financed from rate funds and government grants. Detailed administration was normally entrusted to a Medical Superintendent, who was an officer of the Local Authority, and who held both clinical and administrative responsibilities. Administration followed normal local government practice.

When the new scheme of administration was designed there appears to have been no question of choice of one or other of these two systems, and it might fairly be said that it contains some features of each. Neither system would in fact have been wholly appropriate in view of the decision to work on a group pattern. A Medical Committee for a group of hospitals would be an unwieldy and ineffective body, so medical advice is now given to the Management Committees through Medical Advisory Committees and through medical members serving on the Management Committees. The House Committees, which previously held a position of considerable importance, have, with rare exceptions, either disappeared or have the functions merely of welfare committees. Medical Superintendents of the former municipal hospitals normally remain in office, but are not being replaced except in mental hospitals and institutions, and in sanatoria.

It was clearly right that neither of the two systems should have been adopted, but each left a legacy. Members and officers of the new committees who were formerly connected with the voluntary hospitals tended to resent a limitation of the freedom to which they had become accustomed; those who were connected with the former municipal hospitals tended to regret the departure from local government practice and procedure with which they were familiar. In the early days of the new hospital service each group was critical of the other, and some of the Management Committees were divided into two "camps." The new participant in the service, the Ministry of Health, was naturally inexperienced in the administration of hospitals, and was accustomed to Civil Service routine and procedure.

In these circumstances the partnership of the State and voluntary service was bound to start as an uneasy partnership. The administrative pattern as set out in the Act was necessarily only an outline, and the Act did not provide answers to all the problems

which emerged. The detailed pattern of administration had to be shaped in the light of experience. It is no easy task to create administrative machinery which will fulfil the intentions of Parliament by providing the voluntary partner with an adequate measure of administrative responsibility, and yet ensure the proper use of public funds. The formative years of the new hospital service were certain to be full of difficulties, and it is to the credit of all who have been concerned with shaping the new machinery that despite this major upheaval the hospitals have continued to give a high standard of service to the community.

In our investigations we have become aware of various difficulties which have arisen and which appear to affect the smooth running of the hospital service. We have examined these difficulties as far as we have been able, and, where we have considered it appropriate to do so, we have stated our own opinion as disinterested observers. Some may feel that in doing so we have gone beyond our terms of reference. We do not hold this view. In our experience broad issues are often vitally affected by what may at first seem to be points of detail, and it is our considered opinion that the future of voluntary service in hospital administration, and the future of this new form of partnership between the State and voluntary service, will depend on a satisfactory solution being found to the administrative problems with which this chapter deals.

(b) The Appointment and Composition of the Regional Hospital Boards

The Appointment of the Boards

Under Section 11 (1) of the National Health Service Act the Minister is required to appoint Regional Hospital Boards in accordance with Part I of the Third Schedule of the Act, which reads as follows :

"A Regional Hospital Board shall consist of a Chairman appointed by the Minister and such other members so appointed as the Minister thinks fit, and the members shall include—

(*a*) persons appointed after consultation with the university with which the provision of hospital and specialist services in the area of the Board is to be associated ;

(*b*) persons appointed after consultation with such organisations as the Minister may recognise as representative of the medical profession in the said area or the medical profession generally ;

(*c*) persons appointed after consultation with the local health authorities in the said area ; and

(*d*) persons appointed after consultation with such other organisations as appear to the Minister to be concerned ;

and the original members of the Board shall also include persons appointed after consultation with such organisations as the Minister may recognise as representative of voluntary hospitals in the said area.

Before making appointments to fill vacancies, the Minister shall also consult the Board.

At least two of the members of the Board shall be persons with experience in mental health services."

It is frequently argued that this method of appointment is undemocratic. This argument implies that a committee can only be democratic if it consists of elected representatives, which seems to us to be a narrow interpretation of the term. It is our

belief that the true democratic element, which defies precise definition, is maintained through the voluntary status, irrespective of the method of appointment, and that the members of voluntary boards and committees entrusted with statutory responsibilities are, except in the method of their appointment, representative of the people whose interests they serve. What should be determined is whether this method of appointment is based on sound principles and is reasonably free from the possibility of abuse.

The original appointments, those made in 1947 and 1948, appear to have been made very largely on the principle of securing for the new boards and committees people who had already had experience as members of hospital boards. For the subsequent new appointments this principle does not seem always to have been adhered to, and we have no evidence of other principles having been established yet. There are grounds for believing that party politics are a not inconsiderable factor, but it is reasonable to suppose that any Minister will be subjected to pressure from his own political party, and probably from the Opposition, and that each individual appointment of a person with known political views will offend the opposing party. A Minister will therefore be wise to exercise caution and to avoid laying himself open to criticism, especially by responding too energetically to pressure from his own party. If party politics are an influencing factor it becomes important that officers of the Ministry should not be involved in these appointments since the traditional political impartiality of the Civil Service would be endangered.

It is understood that members of Regional Boards have been appointed as individuals and not as representatives of sectional interests, yet there is evidence that the representation of sectional interests has been noticeable in the Boards' discussions. It is perhaps natural that members of the medical profession should be influenced, to some extent at least, by professional considerations, but even among lay members it is clear that sectional interests, such as local government and Trades Unions, are prominent. It is significant that both the British Medical Association and the Trades Union Congress have passed resolutions stressing the importance of securing increased representation on the Regional Boards and Management Committees.

Any system of direct appointment is open to abuse, and, while it may well produce better committees than would be produced by an electoral system, the possibility of abuse makes it necessary to consider the need for safeguards. Under the present scheme, as set out in the Third Schedule of the Act, the original appointments were to be made by the Minister after consultation with various bodies, and it is laid down that "before making appointments to fill vacancies the Minister shall also consult the Board." The only existing safeguard is therefore consultation with various bodies including the Regional Boards. The word "consultation" is one which may be interpreted in different ways. One Minister may consider that it is adequate to obtain the recommendations of the Boards and thereafter to ignore them if he chooses to do so ; another Minister may feel that "consultation" implies that unless he has good reasons not to do so he should accept the recommendations. We have therefore endeavoured to find out what has been the practice in the filling of vacancies on Regional Boards. Enquiries made have frequently produced the answer that consultation has been "a gesture" and no more. On our asking for examples we have been told that recommendations made by Regional Boards for the appointment of people who were considered to be exceptionally suitable for membership have been rejected, and that the Minister has appointed some people whose claims to consideration seemed to be slight. We think it likely that appointments

are influenced not only by official recommendations but also by privately expressed views, and we appreciate that the position of the Minister is not an easy one. It would be unprofitable to pursue this further, and it must be accepted that the requirement that there shall be "consultation" is not a safeguard against abuse.

The question then arises whether safeguards are needed. We have given this question careful consideration and we are inclined to think that its importance has been exaggerated. It is, in our view, unlikely that any Minister would so use his powers of direct appointment as to impair the efficiency of the Regional Boards; if he did there would surely be widespread criticism which is something of a deterrent in a democratic society. It is likely that there will always be some political appointments, whichever party is in power, but people appointed because of their politics may well prove to be useful members of the Boards.

We have considered the possibility of substituting for the method of direct appointment the alternative of appointment by nomination, but we think that under the present legislation this would not be satisfactory. We feel that since the Minister is appointing bodies to whom he will delegate powers and responsibilities that have been expressly laid upon him personally by Parliament it is only reasonable that the decision should be his. If this view is upheld any system of appointment by nomination must be rejected. We believe, however, that consultation might well be more realistic than it appears to have been, and we think it important that all possible enquiries should be made about people who are being considered for appointment.

No method of direct appointment would satisfy the critic who takes his stand on democratic principle and will accept no board that is not an elected body. We have discussed the practicability of local election with a number of people. It appears to be the general view that *ad hoc* elections would attract so small a proportion of the electorate as to render them worthless, although there are some who maintain that this is a mistaken view. An alternative that has been suggested is that elected bodies in the regions, the major Local Authorities, should appoint representatives to serve on the Regional Hospital Boards, together with a minority of members of the medical profession elected by the profession in the region. This would alter the entire scheme and give control of the hospital service to the equivalent of joint boards of the major Local Authorities in the region: it would in effect be a return to the 1944 scheme. There would appear to be little justification for this major change at present. Presumably control by Local Authorities would have to be accompanied by a revision of the financial arrangements requiring a substantial part of the cost of the hospital service to be met from rate funds, as proposed in 1944. Such a proposal is not likely to be welcomed at the present time by Local Authorities which are already heavily burdened with high rates.

The Composition of the Boards

As it will be seen from Appendix I, the composition of the Regional Hospital Boards does not differ markedly in quality or type of members from that of the major Local Authorities, except that there is substantial and effective representation of the medical profession and the universities. This is natural since, generally speaking, the Regional Boards need much the same kind of people as local government needs. It is perhaps not surprising that the Regional Boards contain a number of members who are active in local government, and who must spend much of their time in attending committee meetings. While it is desirable that there should be members who are concerned in local

government with public health, it would be a pity if the combination of local government and Regional Board work should prevent them from having adequate time for seeing in the field the activities with which they are concerned in both capacities. It is unfortunately common experience in local government that there are members who consider that by attending committee meetings they are giving all the service that is required of them. If the Regional Boards are to work effectively they need to have members who will familiarise themselves with the work of the hospitals throughout the region, and with the problems involved.

A number of members of Regional Boards are also chairmen or members of Hospital Management Committees. In this there seems to have been variation of practice, since one Regional Board includes the chairmen of all but four of the Management Committees in the region, while another Regional Board has no chairmen of Management Committees. The Ministry's present policy is set out in Circular R.H.B. (49) 143, which states :

> "While it may be convenient to Boards to have a few of their own members serving also as members, or very exceptionally as chairmen, of Management Committees, the Minister considers that this duplication of membership should be strictly limited."

It can be argued on the one hand that the experience of chairmen or members of Management Committees is of value to the Boards ; on the other hand it is said that such members tend, somewhat naturally, in Board discussions to favour their own Management Committee's interests to the exclusion of others. In our view the advantage to the Boards of having members who are chairmen of Management Committees, with first-hand experience of the administrative problems of group management, outweighs the disadvantage.

As in local government, the proportion of women members is not high. In 1949-50, of the 370 members of the Regional Boards only 52 were women, which represents 14 per cent. Some people claim that with the large number of women concerned with the hospital service as doctors, nurses or patients, and in other capacities, the proportion should be increased ; others maintain that this is an irrelevant argument and that the proportion of women members is immaterial.

Membership of Regional Hospital Boards is necessarily limited to people who can spare the time to undertake the work. Since this is an important consideration we have made enquiries about the amount of time given by the present members of some of the Boards ; we have taken into account both attendance at committee meetings and also visits to hospitals on business with which the Board is dealing. As would be expected there seems to be considerable variation. The main determining factors are the number of sub-committees on which the member sits, and the frequency of meetings. Chairmen of the Boards and of sub-committees need to give rather more time than other members.

The views of a number of members of Regional Boards have been obtained, and it appears to be generally agreed that a member who is to give full service to the Board on which he serves might be expected to devote 8 to 10 hours a week, or roughly 1 to $1\frac{1}{4}$ working days of 8 hours, to work for the Boards. Members of Regional Boards are normally drawn from different parts of an extensive region and this makes evening meetings impossible. It must therefore be accepted that all time devoted to committee work must be in normal working hours. In the light of this it would seem that invitations

to serve as members of Regional Boards can only be accepted by people who have retired from business or a profession, people of independent means, people who are self-employed or who can arrange their work to their own convenience, people who can obtain the necessary release from their employment, and housewives who can spare the time. With people from all these categories the Boards would in their lay-members have a fair representation of the community.

No great difficulty seems to arise except in the case of people in active employment where acceptance is conditional on release during working-hours being granted. Some employers are more ready than others to release their employees for voluntary public service. It is understood that, as a general rule, employees in nationalised industries are released, but normally for a limited amount of time. There are examples of private employers who are generous in releasing their employees, but there are also examples of release not being permitted. There is no obvious solution to this problem, but it is suggested that, where an appointment is offered to a person in active employment who would be ready to serve, a personal letter from the Minister, by whom the appointments are made, to the employer might facilitate the granting of release. It is felt also that all possible steps should be taken to enable the Boards to acquire a high status in the public esteem, so that employers would regard it as an honour if one of their employees were offered appointment.

Members are entitled to claim their expenses, covering travelling expenses and subsistence, and also payment for loss of remunerative time. It should, however, be mentioned that a person in active employment may, through continued release for public service, lose opportunities of promotion in his employment, and therefore suffer financially. There is obviously no way of providing compensation for this from public funds. It must be accepted that there are people who undertake voluntary service at personal sacrifice, although it is hoped that employers will ensure that such sacrifice is kept to a minimum.

The question of loyalties is one of some importance when there is a system of direct appointment. A person who serves on a public body as an elected representative owes his primary loyalty to the electorate. What is the relative position of a member of a Regional Hospital Board who is not elected but is directly appointed by the Minister of Health?

There seems to be general agreement that the strongest loyalty, which normally over-rides all others, is local loyalty to a particular hospital, a town or a district. This is noticeable not only among members of Regional Boards who are chairmen or members of Management Committees, but also among other members, lay and medical. As already stated, there are some members who, although appointed as individuals, regard themselves as representatives of some particular body; these naturally have a strong loyalty to the body which they represent. Party political loyalties are much in evidence in discussion of matters of principle which invite political controversy.

Another kind of loyalty observed is that to a particular specialty in which the member takes a keen interest; this applies not only to medical members but also to lay members. It is particularly noticeable in discussion of the allocation of money for the development of specialist services in the region.

It has been stated that some members give their loyalty to the Minister as the source of their appointment: this takes the form of unwillingness to engage in conflict with the Ministry on occasions when the policy of the Board does not meet with the approval of

the central authority. This attitude is perhaps natural, but if it were common to the Boards as a whole it would not be likely to lead to the development of that "spirit of lively independence" which the Minister encouraged and which in our view is a vital factor in the scheme.

In some of the Regional Boards there has emerged something in the way of a regional loyalty, but this cannot be expected to become an effective loyalty throughout the Boards. The hospital service regions have, as such, no history or traditions, and they are not in any way cohesive groupings: they contain both urban and rural areas, usually covering several administrative counties. Each of the four Metropolitan regions contains a segment of London and a considerable area outside London. In these circumstances it is difficult to imagine any real sense of regional loyalty developing, except perhaps something of a competitive nature in relation to other regions.

Administration on a regional basis was started during the war. It was never popular with the Local Authorities. Since the war some of the government departments have maintained regional offices, but more for the purpose of administrative convenience than with the intention of establishing a pattern of regional administration. There are therefore no comparable precedents in regional administration of a social service.

Unless the Boards find some over-riding loyalty the sectional interests which are already evident may well in time destroy such cohesion as exists. What then can be the cohesive force? At the present time it is difficult to answer this question. It may be that if the Boards were given a fuller measure of autonomous responsibility and of financial independence the increased collective responsibility would foster a greater sense of unity.

(c) The Appointment and Composition of the Hospital Management Committees

The Appointment of the Committees

Under Section 11 (3) of the National Health Service Act each Regional Hospital Board was required to submit to the Minister a scheme for the appointment of Hospital Management Committees, to be constituted in accordance with Part II of the Third Schedule of the Act, which reads as follows:

> "A Hospital Management Committee shall consist of a chairman appointed by the Regional Hospital Board for the area in which the hospital or group of hospitals is situated and such other members so appointed as the Board thinks fit; and the members shall include—
>
> (*a*) persons appointed after consultation with any local health authority whose area comprises the area or any part of the area served by the hospital or group;
>
> (*b*) persons appointed after consultation with any executive council (constituted under Part IV of this Act) whose area comprises the area or any part of the area served by the hospital or group;
>
> (*c*) persons appointed after consultation with the senior medical and dental staff employed at the hospital or the hospitals of the group, as the case may be; and
>
> (*d*) persons appointed after consultation with such other organisations as appear to the Board to be concerned;
>
> and, in the case of a Committee appointed before the appointed day for a voluntary

hospital or for a group comprising any voluntary hospital, the original members of the Committee shall also include persons appointed after consultation with the governing body of any voluntary hospital concerned.

Before making appointments to fill vacancies, the Board shall also consult the Committee."

Much the same criticisms can be made of this method of appointment as have been made of the appointment of the Regional Boards by the Minister, except that since the appointments are made by a Committee rather than by a single person there may be said to be less possibility of abuse. From enquiries made in several different regions it appears to be the common view that the original appointments made were generally successful, and it has been widely stated that these appointments did not seem to have been influenced by party political considerations. In certain regions there has been criticism of political influence affecting later appointments.

The task of appointing the Management Committees was formidable. The smaller regions, East Anglia and Oxford, had to appoint only 12 and 15 Committees respectively, but the largest region, the South-West Metropolitan Region, had to appoint 52 Committees. The task was made more difficult by the importance of avoiding delay. It is therefore gratifying to find that considerable care was taken in making these appointments.

In view of the significance of the word "consultation," to which we have referred in connection with the appointment of the Regional Boards, we have endeavoured to find out what has been the normal practice in the making of appointments to Management Committees. In general Management Committees seem to be satisfied that the Boards have consulted them adequately and have been ready to accept their advice, but in certain cases there has been criticism of what were considered to be arbitrary decisions by the Board with apparent disregard of the Management Committees' recommendations : the unwillingness of the Boards to give reasons for their decisions when asked to do so has on occasion been somewhat unreasonably criticised.

It appears that, when consulted, many of the Management Committees discuss the matter in full session in the presence of the retiring members. Where this procedure is adopted the Committee normally recommends the reappointment of all the retiring members seeking reappointment, since to take any other course would be embarrassing. There is much to be said for the alternative procedure, which is adopted by a number of Management Committees, of excluding the retiring members from such discussions.

The Ministry became aware that Management Committees might continue from year to year with substantially the same membership, and, in their Circular R.H.B. (49) 143 it was stated that "The Minister sees no objection . . . to the reappointment of a reasonable proportion of the retiring members, but at the same time he considers that Boards should not lose sight of the advantage, on each occasion, of introducing at least some new element into the membership." The Boards will no doubt endeavour to hold a balance between the desirability of continuity and the undesirability of permanence.

In the course of our investigations we have heard much criticism of the "undemocratic" method of appointment. No reasonable alternative has been suggested. There are few who consider local election practicable. We have heard that one Management

Committee has advertised House Committee vacancies in the local press with a view to giving organisations and individuals the opportunity of submitting names, thus widening the field for future appointments. In our view the present method of appointment of Management Committees is reasonably satisfactory, provided that the Regional Boards continue to take all possible care in the making of appointments.

It has occasionally been suggested that the chairmen of Management Committees should be elected by their committees annually and not, as at present, appointed by the Regional Boards for a term of three years. It is argued that a responsible committee should be allowed to elect its own chairman, and it must be admitted that this is a reasonable view. On the other hand a number of people favour the present method of direct appointment on the grounds that it avoids local personal and political conflicts which necessarily lead to unpleasantness and friction. After considering the arguments on both sides we see no reason why the present method should be altered : we feel that there is much to be said for an impartial choice of chairmen.

The Composition of the Committees

The composition of Hospital Management Committees appears to reflect the composition of the Regional Boards on a local basis, and it is our impression that most classes of the community are represented in the people who serve on them. Naturally there is variation according to the type of district, and the composition of a Management Committee in a south-country residential area tends to be somewhat different from that of a committee in a northern industrial area : exactly the same variations will be found in the composition of local government committees.

From the statement in Appendix I it will be seen that, whereas the average age of members is reasonable, younger members are much in the minority ; that the proportion of women members is higher than on the Regional Boards ; and that the groups from which most members are drawn are the medical profession and allied professions, people who are retired or independent, and housewives. It will be seen also that the Local Authorities are strongly represented. Although we use the word "represented" we regard it as important, as indeed does the Minister, that members should serve as individuals and not as representatives. We have been told that some members who are also members of Local Authorities are liable to place the interests of their Authorities before those of the Management Committee, which is clearly undesirable.

Management Committees naturally contain several members who are interested, and in some cases have been interested for many years, in particular hospitals. It is noticeable that some of these members press the claims of these hospitals as against others in the group ; in this kind of way local interests may conflict with group interests.

Demands on the time of members of Management Committees may be said to be somewhat less than the demands made of members of Regional Boards. It is difficult to make any reliable estimate of the average time devoted to Management Committee work since there seems to be considerable variation, but a conscientious member will probably give 6 to 8 hours a week, including time given in hospital visiting and in reading committee papers. Membership of Management Committees is therefore possible only for people who can spare about one working day a week of their time.

The most important question that has arisen in the appointment of Management Committees is whether it is right or wrong to appoint people who are employees in the

hospital service. A number of such people, mainly medical staff, have been appointed. Considered purely as a question of principle it cannot be accepted that the appointment of employees to a Management Committee is sound, since it must be difficult for them to disregard self-interest entirely, and this must be a limiting factor to their value as committee members. There are, however, arguments in favour of the appointment of members of the medical staff. In the first place it was a traditional practice in many of the former voluntary hospitals to have honorary medical staff on the governing body, and in that setting it seems to have worked satisfactorily. Secondly, the Management Committees need medical advice, and it is reasonable to argue that such advice can best be given by the senior medical staff of the hospitals in the group.

The views of the Ministry are stated in Circular R.H.B. (49) 143, as follows :

"(*a*) The Act requires consultation of senior medical and dental staff—through staff committees of hospitals or groups or other convenient channels—and it is clearly intended that one element in the membership of Committees shall be this professional one. The proportion of professional members should not, however, be high. It is very undesirable that in the composition of Committees any professional element should form a substantial proportion of the members. The Committee must essentially be and remain a group of non-professional members of the local community, rendering voluntary service in the public-spirited tradition of the past and in the interests of the community ; and any implication that the Committee was a body more likely to be concerned with the interests of the staff than those of the community would be most unfortunate.

(*b*) Medical and dental members should normally be derived, as implied by the Act, from names proposed by the hospital staffs and not from other sources.

(*c*) In general, for the reasons given, officers of committees should not be appointed as members of them (i.e., officers who, though legally the employees of the Board, are appointed and dismissed by the Committee concerned). There is less objection to the appointment of the officers of one Committee to be members of another, but even here the considerations in (*a*) above still apply. (Officers including doctors and matrons should of course be invited freely to attend meetings of Management Committees and their sub-committees, and it is by attendance as advisors in this way rather than as members that they can make the fullest contribution to the work of the Committees)."

In a later circular, R.H.B. (50) 105, it is stated that : " . . . Boards should not appoint a Management Committee's officers as members even of another Committee unless there are exceptionally strong reasons for doing so." In view of the fact that the principle of appointing employees as members of Management Committees is open to criticism we have considered whether medical advice can be given to the Committees in any other way. It would seem that there are two alternatives—that each Management Committee should have a group medical adviser in the same way as the Regional Board has a regional medical adviser (the Senior Administrative Medical Officer), and that the senior medical staff of the hospitals should give medical advice by attending meetings of the committee as advisers and not as members.

We are of the opinion that the first alternative would not be satisfactory. In the first

place we are informed by reliable judges that to the lay committee a consensus of medical opinion is generally of more value than the medical opinion of one person, especially in view of the high degree of specialisation in the profession. Secondly, it is doubtful whether the senior medical staff of the hospitals would have full confidence in the medical advice that was given by one medical adviser. The second alternative is one which appears to have less objection. It might be argued that a lay committee might have to make a decision on conflicting medical advice, or that they could reject the medical advice given by their advisers, but this could equally be argued in relation to the present system since medical members of the Management Committees are always in a minority. After careful consideration we are of opinion that the policy of the Ministry, as given in Circular R.H.B. (49) 143 is the right policy at the present stage of development of the hospital service.

(d) The Functions of Regional Hospital Boards and Hospital Management Committees and their Relationship to the Ministry of Health and to each other

(*i*) *The Administrative Pattern*

Consideration of the administrative pattern of the new hospital service suggests that there are two conditions essential to its successful operation. One is that the Minister and his officers shall trust the Regional Hospital Boards and Hospital Management Committees, and the other is that these Boards and Committees shall undertake their work with a clear appreciation of their relative functions and with a full sense of responsibility.

If it is desired to attract men and women of quality and ability to voluntary service of this kind, and to retain their interest, these committees must have reasonable freedom of action and decision, and this is possible only on a basis of trust and delegated responsibility. Busy men and women will be unwilling to give up their time to serve on committees which exist merely to carry out the instructions of a higher authority ; there is evidence of this in the discontent shown in recent years by members of Local Authorities as a result of increasing loss of functions and responsibilities and a corresponding increase in centralised direction and control.

The definition of relative functions and responsibilities in the National Health Service Act is necessarily incomplete, but Sections 11 and 12 of the Act show that it was the intention of Parliament that the Regional Boards should be the agents of the Minister in their Regions, and that the Management Committees should be the agents of the Regional Boards. This interpretation was amplified by the Ministry by regulations issued in 1948, and by an explanatory circular (Circular H.M.C. (48) 1) from which the following extracts are taken :

"*General Structure of the Service*

1. The National Health Service Act (Section 3) lays on the Minister of Health the duty of providing hospital and specialist services. The Minister becomes directly answerable to Parliament for the discharge of that duty, and his responsibility covers the whole field of physical and mental health.

2. The Act contemplates (Sections 11 and 12) that the Minister will discharge this duty principally through Regional Hospital Boards, acting as his agents, and that for the control and management—that is, for the whole business of day to

day administration—of individual hospitals or groups of related hospitals, Hospital Management Committees will in turn act as the agents of the Regional Boards.

3. Broadly, the effect of this administrative structure is that the function of the Regional Board is to determine, in consultation with the Minister and as a fluid and continuously developing process, the part which each hospital is to play in the integrated service, to deal with wider regional problems, and to oversee the operation of the hospital service of their area ; that of the Management Committee is to administer its hospital or group so that it plays its part in the most effective manner. While operational responsibility thus rests with the Management Committees, powers of central control through regulations and directions are reserved to the Minister because of his ultimate responsibility to Parliament, and his power of directing Management Committees is reserved to the Regional Boards as the bodies immediately responsible to the Minister for the administration of the service as a whole. But it is the Minister's intention that this ultimate power—which flows inevitably from the agency relationship—should be exercised both by himself and by the Regional Boards as infrequently as possible ; that normally the ordinary process of administration will suffice to ensure that the general policy of the service is observed ; and that the Management Committee should from the outset enjoy a real measure of responsibility within their own sphere.

Functions of the Committee

16. In framing the regulations the Minister's object has been to avoid prescription in detail of the manner in which the various bodies are to perform their functions and, by laying down the division of responsibility in broad terms, to allow the greatest possible measure of flexibility and variety in administration. His desire is to rely on the ordinary method of guidance by way of advice on questions of policy, and not on a detailed code of rules embodied in regulations, for the purpose of maintaining the necessary degree of unity and homogeneity in the service.

19. . . . As already stated, the scope of the services to be provided at or in connection with the different hospitals will be determined by the policy of the Board and the Minister : the task of the Management Committee will be to secure their efficient maintenance and administration. Within the limits of its approved budget, and subject to any guidance given by the Board or the Minister, each Management Committee will be able to organise the day to day operation of its services as it thinks fit."

We feel that the pattern of functional relationships set out in this Circular is one which would attract able men and women to serve on Regional Boards and Management Committees, since it declares the Minister's intention to establish an agency basis at each stage, and since it indicates that Regional Boards and Management Committees would "enjoy a real measure of responsibility within their own sphere." We have tried to discover whether these functional relationships are effective in operation. In this section of our report we give our findings on the working of the Regional Boards and

Management Committees and on the inter-relationship of the voluntary and statutory bodies.

(ii) The Functions of the Regional Boards and Management Committees

In 1948 the functions of the Regional Boards and Management Committees were defined by regulations (S.I. 48/60) and by explanatory Circulars—Circular R.H.B. (48) 2 to the Regional Boards and Circular H.M.C. (48) 1 to the Management Committees. The Circular to the Regional Boards is on much the same lines as that to the Management Committees already quoted, but the following statement, which refers to the functions of the Regional Boards in somewhat stronger terms than in the Circular to Management Committees, should be quoted: " . . . (the Regulations) are designed to confer on Regional Hospital Boards, acting as the Minister's agents, the powers necessary to enable them to guide and control the planning, conduct and development of the services in their area . . . " The use of the word "control" in this statement does not seem to be entirely in accord with the statements in Circular H.M.C. (48) 1 which indicate that, apart from the reservation to the Minister and to the Boards of powers of direction which were to be used infrequently, a Management Committee was to have a substantial measure of administrative freedom to "organise the day to day operation of its services as it thinks fit." Since 1948 there has been no further attempt by the Ministry to give a detailed definition of the functions of the Regional Boards and Management Committees, but the functions have in effect received further definition through cumulative decisions conveyed in circulars.

It is clear from the circulars of 1948 that it was then the intention of the Ministry, interpreting the terms of the Act, that the Regional Boards should plan the "hospital and specialist services" in their regions, provide regional services as necessary, and "oversee the operation of the hospital service of their area" or, in the stronger terms used in the circular to the Regional Boards, "guide and control the planning, conduct and development of the services in their area." In practice, after two years of operating the new service, the Regional Boards have become primarily administrative bodies standing between the Ministry and the Management Committees and exercising functions which appear to exceed those of an overseer, and which in some regions can more accurately be described as those of a controller.

This seems to be due partly to the deterioration of the country's economic position, partly to the Ministry making use of the Regional Boards as administrative bodies through which the Management Committees can be directed more frequently than was expected, and partly to Regional Boards adopting administration as their primary function of their own volition. Where there has been a lack of detailed definition by the Ministry, Regional Boards have tended to define their own functions in administrative practice.

It has been the policy of the Ministry to establish one hospital service for the whole country, administered through the fourteen regions, and the Ministry has not encouraged regional interpretation and variation of its central policy. Nevertheless in some respects it would be true to say that there are different regional hospital services, made different from each other by the Boards' varying methods of administrative practice and varying conceptions of their functions. Some of the Boards have adopted a policy of "non-intervention" with the Management Committees, and undertake their administration, so far as they are allowed to do so, on this basis; others appear to regard the Management Committees as being in the nature of sub-committees of the Board, and undertake

their administration accordingly. Where the former policy is adopted the functions of the Management Committees broadly reflect the letter and the spirit of Circular H.M.C. (48) 1; where the latter policy is adopted "control" is a more adequate description.

In certain regions we have heard complaints from members and officers of Management Committees of direct interference by the Regional Board in the day-to-day administration of the hospitals, and from time to time we have found justification for such complaints. A less vigorous criticism that has been frequently expressed is that the Boards are in effect "expensive post-offices" causing administrative delay by referring to the Ministry matters referred to them by Management Committees, a criticism which, if justified, might be due to the Board being over-cautious in taking responsibility for decisions, or equally might be due to the Ministry not giving the Boards adequate powers of decision. It is difficult to say how much, if any, of this kind of criticism is justified, the more difficult since the amount of justification will vary from region to region. It is even more difficult to apportion blame, if blame there should be. What seems to be needed is a clarification of functions based on the experience gained in the operation of the service.

The basic question that arises is whether the Regional Boards should be essentially administrative bodies standing between the Ministry and the Management Committees, or whether they should be essentially planning and co-ordinating bodies exercising an entirely different function from that of the Management Committees and standing outside the main stream of administration.

We feel that the original conception of the Boards as planning and co-ordinating bodies, with the duty of overseeing the operation of the service in their area, should not be abandoned. We would regard it as a misfortune if the mass of administrative detail with which the Boards were concerned left no time for planning as "a fluid and continuously developing process." At the same time we believe that it will be in the interests of the service for the Regional Boards to continue their present administrative functions, at least for a further period, provided that they are given by the Ministry adequate responsibilities and powers of decision.*

We would like to see the Management Committees given a substantial measure of administrative autonomy, but we doubt whether they are all yet ready to accept the responsibilities that would be involved. It may well be necessary in these early stages in the development of the service for the Regional Boards to take the major administrative responsibility and gradually to increase the extent of the authority delegated to the Management Committees as the working experience of the Committees grows. The point that appears to us to be of primary importance is that the administrative responsibilities should be entrusted to the voluntary partners—the Regional Boards and Management Committees—as was intended by Parliament, and we believe that the central authority will more readily entrust these responsibilities to a relatively small number of Boards than to nearly four hundred separate Management Committees. We believe, moreover, that, if the central authority were dealing administratively with a large number of separate Committees direct, there would be a much greater danger of increasing central control than if they were dealing with a small number of Boards which could, if they felt it necessary, act together. At the same time we feel that the Boards should give to the Management Committees the greatest possible freedom of action and decision within the general regional policy. In our view it is important that delegation,

*See Note on the Eleventh Report of the Select Committee on Estimates (Appendix II, pages 126-127).

from the Ministry to the Regional Boards and from the Boards to the Management Committees, should be a reality and not a facade, and that the Boards should exercise the functions of overseers rather than those of controllers.

One further point should be mentioned. Under Section 14 (1) of the National Health Service Act the Regional Boards are made the sole employers in the Hospital Service other than in the teaching hospitals, and by regulation they are made the appointing body for all officers other than those employed "for the purpose only of the hospital or group of hospitals." There is much to be said in favour of the principle that all appointments should be made by the committee responsible for the management of the hospitals in which the persons appointed will work, but, in view of the consultants service being organised broadly on a regional basis, it is arguable that an exception should be made to this principle and that the appointments should, as at present, be made by the Boards. The Act requires the Boards to set up Advisory Appointments Committees for all such appointments, and lays down that such committees shall include persons nominated by the Hospital Management Committees of the hospitals affected. We consider that this method of associating the Management Committees with appointments compensates to some extent for their limited powers of appointment. We suggest, moreover, that it points a way to a means of strengthening the relations between the two bodies. We feel that if the Regional Boards would take every opportunity of active consultation with the Management Committees in the formulation of policy it would be of great benefit to the administration of the hospital service.

(*iii*) *The agency relationship*

Ministry of Health Circular R.H.B. (48) 2 refers to "the agency relationship which is the principle running through the administrative structure of the service." The term "agent" can be used to cover a variety of relationships, and an agent may in some instances prove to be no more than an employee acting on direct instructions from his employer. It is however clear that in the administration of the hospital service the Boards and Committees were to be agents with "a real measure of responsibility within their own sphere." That they were not intended to be bodies acting on direct instructions from higher authority is indicated in the statement in Circular H.M.C. (48) 1 that the ultimate power of higher authority, the power of central control in the hands of the Minister and the Regional Boards, "which flows inevitably from the agency relationship—should be exercised both by (the Minister) and by the Regional Boards as infrequently as possible."

From our examination of this system of administration in operation we do not feel that the promise of these circulars has been fulfilled: indeed there appear to be signs of increasing direction and control exercised by the Ministry and reflected, to some extent, in some of the Regional Boards.* The Ministry's direction of the service is carried out by the issue of Statutory Instruments, which lie on the table of the House for a prescribed period of time before issue, and by circulars which do not require Parliamentary sanction. In the two years from June 1948 to June 1950 there were issued 29 Statutory Instruments, 263 circulars to Regional Boards and Management Committees and 44 circulars to Regional Boards only. It is true that these circulars frequently contain suggestions rather than direct instructions, but the former are generally interpreted as the latter. The danger of increasing central control through this method was pointed out by Karl Mannheim in "Man and Society" in which he wrote: " . . . it is

*See Note on the Eleventh Report of the Select Committee on Estimates (Appendix II, pages 126-227).

becoming more and more obvious to-day that administration is turning into an instrument of political interference, and that the methods used in executing the prescribed regulations can serve as an indirect means of altering the balance of power in a society."

It may well be argued that since 1948 the position has been completely altered by serious economic pressure combined with an alarming rate of expenditure on the new service in the first year of its operation. That these are important factors no one will deny, but we would regard it as unfortunate if the administrative patterns had to be dictated not by the needs of the service but by economic pressure. There seems to be a real danger that, in order to meet an immediate and grave situation, permanent harm may be done to a service which in many respects is an example of imaginative and intelligent planning.

From the start it was clear that although in its administrative pattern the hospital service was to break new ground, its finance was to be administered in accordance with the traditional established practice which placed control almost exclusively in the hands of the central authority. Thus, it seems to us, even from the start the agency relationship was bound to be limited. It has been stated that the absolute personal responsibility of the Minister to Parliament controls the extent to which any Minister will be willing to delegate his responsibilities to the Regional Boards and Management Committees, particularly his financial responsibilities. This is a point of fundamental importance. If, by reason of the Minister's absolute personal responsibility to Parliament, the delegation of powers to the Regional Boards and Management Committees must be strictly limited—and it is not unreasonable for a Minister to be cautious in the delegation of what are his personal responsibilities—it would seem that the whole agency relationship inevitably breaks down. If this view is maintained it is unfortunate that the original circulars were issued, since they gave the men and women who accepted appointment to these Committees a false impression of what their responsibilities would be.

We have heard it said that the administration of the service cannot work successfully unless the Minister's agents are subservient to his wishes, and that the voluntary status of the agents cannot be accepted as a justification for their taking a stand in opposition to the Minister. Such an argument is in strange contrast to the statements made by the Minister encouraging the committees to have "a spirit of lively independence." The fact that such statements are made and are, to some extent, reflected in the actions of the central authority, make us feel that the apparent contradictions must be resolved in the near future so that the voluntary agents of the statutory authority may know where they stand.

It has already been said that there are signs of increasing direction and control of the service by the Ministry. A number of examples could be given, but two will suffice.*

In 1949 the duty of approving the estimates of Hospital Management Committees was entrusted to the Regional Boards, leaving to the Ministry the approval of the total regional estimates. In 1950 this duty was removed from the Boards and was kept in the hands of the Ministry. In effect this "by-passes" the Boards, and it is interesting to note that in Circular R.H.B. (50) 109 the Ministry, referring to this, states that it "in no way derogates from the responsibility of the Boards" and entrusts to the Boards the functions of scrutiny and revision, functions which, though important, do not contain the same measure of responsibility as the function of approval.

*See note on the Eleventh Report of the Select Committee on Estimates (Appendix II, pages 126-127).

In May, 1950, the Ministry, acting under the pressure of economic stringency, issued Circular R.H.B. (50) 41. After instructing Regional Boards and Management Committees to submit monthly statements of expenditure the Circular ended with the following paragraph :

> "*Liaison with the Department.* It will clearly assist both the Minister and Boards and Committees in keeping a close watch on expenditure if the Minister is in constant touch with the work of Boards and Committees as it proceeds. It has, therefore, been decided that for liaison purposes arrangements should be made for the Principal Regional Officers of the Ministry, or their Deputies, to be kept informed of the proceedings of Boards and Committees by receiving regularly copies of the agenda, papers, and Minutes of all meetings of Regional Boards, Boards of Governors, and Hospital Management Committees (but not of committees or sub-committees unless they ask for these), and by attending such meetings as appears to them desirable. Accordingly, Boards and Committees are asked to arrange for the above documents for all their meetings held after the date of this memorandum to be sent to the officers indicated in the Appendix."

We have been informed that some of the Regional Boards made a protest to the Ministry on principle, stating that by legislation they were the agents of the Minister in their regions and that there was no place in the administration of the hospital service for other agents of the Minister in the regions. It was said that the function of these officers would clearly be to report privately to the Ministry on the activities of the Regional Boards and Management Committees. It seems to us that these protests were justified, and that the Ministry's instructions were contrary both to the spirit and to the letter of the Act and of Circular H.M.C. (48) 1. Indeed it shows little sign of the trust on the part of the Ministry in its voluntary agents that we consider to be indispensable to the successful operation of the service. The fact that it was dictated by extreme economic pressure does not seem to us adequate justification for violating an important principle in functional relationship.

It is nevertheless reasonable that the Ministry should be kept well informed about activities in the field, and we feel that there is much to be said for the establishment of a properly qualified Inspectorate, as was provided for in the 1944 scheme. Such an Inspectorate could be organised much on the lines of the Inspectorate of the Ministry of Education, and we feel that, if in its relations with the hospitals it followed the pattern of relationship that has in the course of time been established between that body and the schools, it would be of much benefit to the service. It is our view that visits to hospitals by properly qualified inspectors, who had themselves had hospital experience as medicals or laymen, would be welcomed by hospital committees and staffs.

We are aware that in the early years of its work a new administrative scheme is likely to suffer from the lack of established procedure. Examples of this are to be found in the administration of the hospital service. We have, for instance, been informed that there have been occasions when Management Committees have submitted direct to the Ministry proposals which have been turned down by the Regional Board, and have received the Ministry's approval, which was given without consultation with the Board. We are confident that such a procedure would not meet with approval at the Ministry, and that in the instances quoted to us there were administrative mistakes, but it is unfortunate that such a thing could happen.

If the Regional Board is used as an administrative unit it must be accepted as the

direct channel between the Ministry and the Management Committees, and *vice versa*. At present there is some direct dealing between the Ministry and Management Committees, and some officers of Management Committees have stated that they correspond direct with the Ministry in order to save administrative delay. We regard this as unfortunate and feel that the Ministry ought to discourage this practice. The right of direct approach by a Management Committee to the Ministry is one which should be admitted, but it should be used only exceptionally.

We have also been given examples of what seem to be unfortunate administrative practices on the part of some Regional Boards in their dealings with Management Committees. For example, we have been informed that in certain cases a decision of a Management Committee has been reversed by a Regional Board without consultation with the Committee. Again we were informed that some of the Regional Boards, on being instructed by the Ministry to secure a reduction in their regional estimates, have decided on reductions in the estimates of Management Committees under detailed headings, whereas in our view it would have been wiser for these Boards to have decided overall reductions and to have left the Management Committees to deal with the detail, a procedure which some of the Boards followed, or at least to have made the decisions after consultation with the Management Committees. Arbitrary decisions from a higher authority never improve relations.

The relationships between the Ministry, the Regional Boards and the Management Committees are of great importance, and it is our view that all possible steps should be taken to ensure that they are successful. In our experience successful relations are best established and maintained by personal contacts. The Minister meets the chairmen of Regional Boards frequently, and the chief officers of Regional Boards meet the senior officers of the Ministry frequently also. We commend this practice, but we feel that it would be of advantage if the senior officers of the Ministry were able to visit the offices of the Regional Boards from time to time and see on the spot some of the problems which to them normally exist only on paper.

Similarly we feel that chairmen of Regional Boards should be at pains to establish and maintain personal contact with the chairmen of Management Committees. We are aware that several of the chairmen have already taken steps to achieve this, and we are also aware that some of the chairmen have little available time, but we believe that in some regions more personal contact is needed to counteract what in one region was described to us as "the growing rift between the Board and the Management Committees." In contrast to this it should be stated that in some regions we have had evidence of satisfactory relations and mutual confidence between the Regional Board and the Management Committees.

The success of any organisation depends, to a considerable extent, on the relationships within the organisation, and we feel that in the administration of the hospital service the experience of three years has shown that relationships between the central authority and its voluntary agents and sub-agents would be greatly improved if there were a clarification of relative responsibilities and increased personal contact within the service.

(iv) Financial Administration

The system under which public funds are administered in this country is one which is hallowed by tradition. It is a system that is designed to prevent any possibility of misappropriation or irresponsible spending. The Civil Service has a proud record of

integrity, yet, even so, the power of authorising expenditure is strictly limited : ultimate authority rests with Parliament but is exercised by the Treasury. All spending departments are required to submit annual estimates, from which the Parliamentary Estimates are framed, and provision is made for the submission of supplementary estimates when necessary. Approval of estimates does not however bring with it approval of all expenditure within the estimates ; any expenditure that is not routine expenditure requires additional approval by the Treasury. It is a cardinal principle that savings on estimates return to the Exchequer : spending departments are not permitted to retain reserve funds.

No responsible person would question the importance of ensuring that public money should be properly spent and not used extravagantly. It seems however to be open to question whether the present system achieves this end, and there are many people who claim that an extension of delegated financial authority would increase both efficiency and economy. In fact there has been an appreciable move in the direction of increased central control. A generation ago it was generally accepted that the function of the Treasury was to finance as far as possible the policy determined by the specialist departments. Control was exercised over extravagance, and the rate at which a policy could be put into effect was controlled by the availability of finance. Almost imperceptibly the emphasis seems to have changed, and the stage seems to have been reached at which the policy of the public services is determined largely by the Treasury. Side by side with this has emerged an attitude of suspicion which has replaced an attitude of mutual confidence. A succession of checks and counter-checks have been introduced at considerable cost to ensure that public funds cannot be spent irresponsibly, yet there are grounds for believing that the result is the reverse of what was intended, and that increasing financial checks are an incentive to evasion.

When the National Health Bill of 1946 was before the House of Commons it appeared from the debates that the new pattern of administration of a public service which the Bill was designed to introduce might bring with it a system of financial administration which departed from tradition in at least some important respects. The Minister stated, for instance, that it was intended to try "global budgets" and "to give the Regional Boards and the Hospital Management Committees freedom of movement within the budget so that they will not need sanction for each item of expenditure." This was reflected in Circular H.M.C. (48) 1, as follows :

"*Finance*

43. For the ordinary purposes of the hospital and specialist services Management Committees will be financed by the Regional Boards, whose expenditure, including that of the Committees, will be defrayed by the Exchequer subject to its having received the Minister's approval. For this purpose Committees will be required to submit to the Regional Boards, each summer, budgets covering their anticipated expenditure under specified headings for the year running from 1st April following. These budgets will be reviewed by the Boards and submitted to the Minister for approval. When approved, Committees will be free to proceed within the agreed framework as laid down in regulations to be issued presently. There will be provision for supplementary budgets and for authorising savings on one heading of expenditure to be used to meet excess expenditure on other headings where appropriate."

The period July 5th, 1948 to March 31st, 1949, was covered by a preliminary estimate based on such information as was available on hospital expenditure in the year 1946. This estimate proved to be much too low, and the estimate put forward later for the Financial Year 1949-1950 showed a substantial increase: this estimate also was based on very little reliable information since the Regional Boards and Management Committees had hardly been constituted before their estimates were required. The period 1949-1950 was one of steeply rising expenditure, culminating in a debate in the House of Commons on March 14th, 1950, when the Chancellor of the Exchequer presented a supplementary estimate of nearly 100 million pounds for the health services: of this estimate £39,200,000 was for the hospital service, increasing the total estimate for the hospital service to over 200 million pounds. In presenting these estimates the Chancellor said:

> "It is necessary to call a halt to further development of these services. We must therefore regard the estimates for the forthcoming years as a ceiling . . . we must find some means to associate the Minister of Health more directly with the Management Committees and the Regional Boards, so that both he and I may be assured that there is no possibility of the budgets being exceeded once they are passed, or of the savings on one sub-head being dissipated unnecessarily upon another . . . The objective is, therefore, to place a ceiling upon total expenditure and reinforce the present system of budgeting control."

Sagittarius in *The New Statesman and Nation* summarised the position trenchantly in verse:

> "Economy henceforth will be the goal,
> With budgetary limits for the whole.
> The total cost of healing
> Will be underneath a ceiling,
> And the ceiling under Treasury control."

In the course of the debate Dr. Charles Hill, M.P. prophesied further necessary increased expenditure on the hospital service, and, referring to the financial system, said: "The Minister of Health has rightly proclaimed his intention to permit the highest possible measure of local responsibility and local autonomy, and the difficulty which has to be resolved is how to reconcile that local responsibility . . . with central financial control." We believe this to be the core of the problem.

We have endeavoured to assess the extent to which the system of financial administration that has been applied to the hospital service is inappropriate to the needs of the service and injurious to the work of the voluntary boards and committees. We have found a considerable weight of informed opinion that is critical of the present system. Its main defects, so we have been informed, are that, since Management Committees are required to estimate their financial needs six to nine months ahead of the financial year concerned, the estimates are certain to be speculative, and are often, as a precaution, higher than they need be; that the administrative procedure tends to cause delay in approval of the estimates and thus leaves the Management Committees for a substantial period uncertain of their financial position; that the system is not sufficiently flexible to meet the constantly changing position in the hospital service; and that the system encourages extravagance by requiring all savings on approved estimates to be returned to the Exchequer. We propose to examine briefly each of these four points.

The need for estimating by Management Committees a long time ahead of the period

for which they are estimating is due to the need under the present system of providing the required information for the parliamentary budget. Time must be allowed for scrutiny, and perhaps revision, by the Regional Boards and the Ministry, and thus the Management Committees have to prepare their figures "each summer" at a time when their full statements of accounts for the previous financial year are probably not completed.* Management Committees have been made to realise that they will not be allowed supplementary estimates, and some Committees, perhaps wisely in the circumstances, tend to inflate their estimates to provide for unforeseen contingencies. There is little doubt that but for this the maintenance estimates of some of the Management Committees could be substantially reduced without injury to the service provided.

Experience has shown that the approval of the estimates may not reach the Management Committees until well after the new financial year has begun. This will not, of course, hinder the normal running of the hospitals, but it may delay the provision of new equipment for which special provision has been made, or the carrying out of necessary repairs and replacements of a special nature.

The lack of flexibility may well be a serious matter. Medical science is constantly developing and creating changes in technique and equipment. Without flexibility, and the availability of some financial reserves, a hospital may have to wait for a substantial period before new methods of treatment can be introduced, even if economies can be made to offset any new expenditure. When human life and welfare are involved such delays cannot be accepted with equanimity.

The requirement that all savings made should revert to the Exchequer encourages Management Committees to be extravagant. With the uncertainty about the availability of money, Committees tend to proceed with caution until the last few months of the financial year, and then try to spend all that is left of the money allocated to them before the financial year comes to an end. This contrasts strangely with the doctrine of enlightened economy preached by Florence Nightingale.

It seems clear that the present financial system is not working well, and is even tending to cause extravagance rather than check it. Its greatest weaknesses seem to us to be that it is not flexible and that it removes the direct responsibility for economy from the boards and committees which are responsible for hospital administration. With flexibility in its application the present system might be workable. In its essentials it does not differ greatly from systems used with success by private firms, but it differs in its speed of operation and in its lack of direct and immediate discussion of points of importance that arise. Moreover, private firms are always in a position to adapt their financial administration to their own particular needs, and no board of directors would tolerate the kind of defects which appear to exist in the financial administration of the hospital service. A system which is applied generally to the public service cannot, however, easily be adapted to meet the particular needs of one part of the service.

We do not think that the difficulty of estimating expenditure some time ahead is as great as some people claim it to be. Old established hospitals, such as the teaching hospitals, are able to estimate their financial needs in advance with fair accuracy. Hospital Management Committees are new to their tasks and many have been faced with the difficulty of lack of information on the cost of running the hospitals in their charge :

*Ministry of Health Circulars, R.H.B. (51) 84 and H.M.C. (51) 77, which were issued in August, 1951, after this chapter was written, announced an important alteration in the timetable for the submission of estimates which removes all the difficulties referred to above.

furthermore, price levels in the last few years have been rising rapidly. We believe that, when the results of the work being done by King Edward's Hospital Fund for London and the Nuffield Provincial Hospitals Trust in the compilation of uniform standards of costing are available, Management Committees will be able to base their estimates on surer foundations. Estimates of some kind will be needed whatever financial system is used. What is wrong is not that there must be estimates, but that the boards and committees should be rigidly bound by the detail of their estimates : this can only cause them to take no risks and inflate their estimates to provide for all contingencies. When this is seen in the light of the reversion of all savings to the Exchequer it will be appreciated that there is a strong incentive to extravagance ; money provided, however unnecessarily, will if possible be spent since it will no longer be available when the financial year comes to an end.

Since it appears to be impracticable to adapt the present financial system to the special needs of the hospital service, we have considered whether an alternative system might be introduced which would reconcile local responsibility with central control. In our examination we have applied two criteria. We have recognised that the Minister is, under the National Health Service Act, personally responsible to Parliament for the expenditure on the service, and have accepted the implication that the financial system must be one over which he has adequate control. At the same time, believing that a full measure of delegation of financial authority to the voluntary boards and committees would bring in return a full measure of responsibility on their part, we have only been ready to accept a system which provides them with adequate responsibilities. These two criteria are not incompatible if the administration of the service is accepted as a partnership between the State and voluntary service, with the implication that responsibility is shared by the partners.

It has been represented to us that the best and most appropriate financial system would be one providing for allocation by the Minister to the Regional Boards, either annually or possibly for longer periods such as three years or five years, of such money as was needed for the administration of the hospital service in the regions, responsibility being entrusted to the Boards to incur expenditure within the allocated amounts as they thought fit, and unexpended balances being retained in reserve accounts to meet emergency needs without recourse to supplementary estimates.

There appears to be much to commend in this proposal. It would, we believe, give adequate financial control to the Minister and, at the same time, a substantial measure of delegated financial responsibility to the voluntary boards and committees, thus satisfying the two criteria which we have adopted. It would be a system that was based on mutual confidence rather than mutual suspicion, and there are good grounds for believing that it would bring back a policy of enlightened economy in hospital administration.

The arguments in favour of this proposal were well stated by Sir Lawrence Bragg in a letter to *The Times* of March 6th, 1951, as follows :

> "All would agree that the expenditure of public money must be subject to close scrutiny. While it is essential to check that there is no corrupt use of the money, it is of equal importance to have a system which leads to the maximum value being extracted from every pound which is spent. The system of close control defeats its own ends as regards the latter aim, and the tighter the control is drawn the greater is its failure. The block grant corresponds in the humbler domestic sphere

to the housekeeping or dress allowance. It is an incentive to thrift, for any administrator worthy of his job enjoys making the money go as far as possible. He has a feeling of pride in creating a brave show. It makes experiments possible, so that an organisation is dynamic and not static, and individual initiative is encouraged. It enables fleeting opportunities to be seized without delay by those who are in direct touch with local conditions. The necessary check is made at the end of regular periods when an account of stewardship has to be rendered and application for the next grant made.

The system of detailed central control leads to a great waste of time and energy in 'making a case' which has to go for decision to some central authority who cannot know local conditions or appreciate all the local technical problems. Its worst feature, however, is that the making of a case tends to become a game in which the public purse suffers. The relative ease with which money can be got for different projects often bears little relation to their relative importance. The applicant must make a generous estimate of what he needs for each item, for he cannot risk being caught short in so inelastic a system. If he gets the money it is up to him to show that he really needed it by ensuring that it is all spent before the year is up. . . . In brief, if the central administration insists on having the final word in matters of detail, the sense of responsibility tends to be lost. If we become slaves of a bureaucratic machine we develop the slaves' point of view, that it is fair to cheat our master . . . I believe that nationalisation can only succeed if it is accompanied by decentralisation and devolving of responsibility."

In its issue of April 28th, 1951, *The Economist* stated :

> "What is virtually certain is that there will be pressure to increase the hospitals' budgets year after year so long as the present system of financing them is maintained. At the moment those responsible for running the hospitals have a direct incentive to overbudget and to spend on unessentials. Until they are allocated a certain sum, and given freedom to spend within that sum, no real economies in the service will be made."

A small step towards the adoption of such a system has already been taken. The Regional Boards are allocated sums of money for the financing of the hospital and specialist services in their regions, and they are empowered to approve proposals from Management Committees for the transfer of savings on one sub-heading of the estimates to another sub-heading. But the main principles of the "block-grant" proposal have not yet been adopted ; the Boards and Management Committees are not free to use money allocated to them as they think best, and they are not entitled to retain any savings that they make.

There would be some advantages if financial allocations were made for periods of more than a year at a time. Boards and Committees would be able to plan ahead and carry out "long-term" programmes. On the other hand in the present economic position of the country it is improbable that any government would commit itself to a particular level of expenditure on any new social service for more than one year ahead.

Administrative freedom within approved estimates would demand careful "housekeeping." It would be possible for a Management Committee to spend all the money allocated to it well before the end of the year and then demand additional money with the threat of closing down the hospitals if it were not granted. We have enough confid-

ence in the voluntary boards and committees to express the belief that this would not happen, but we must accept that it might happen. In our view it would be an adequate safeguard if the Regional Boards were given the responsibility of supervising the financial administration of the Management Committees continuously.

We have heard it argued that Parliament would be unlikely to agree to the delegation of authority for the expenditure of over 200 million pounds a year to bodies of the nature of Regional Hospital Boards. It is difficult to attach much weight to this argument. In the first place the money would not be allocated to the Boards until the central authority was satisfied that such sums were in fact needed : indeed the only practical difference from the present system would be the restoration to the Boards of the power of approval of Management Committee estimates. Secondly, the Regional Hospital Boards are statutory bodies, set up under the National Health Service Act of 1946, and given the duty of operating the hospital service in their regions as agents of the Minister.

Stronger objection is likely to be raised to the proposal that Regional Boards and Management Committees should be empowered to retain unexpended balances in reserve accounts. It will be maintained, correctly, that such a proposal is contrary to accepted practice in public administration. It will also be said that if the Boards and Committees are allocated more money than they actually need the money will be spent and not saved. We do not believe this to be true, and we feel that extravagance of this kind is not only equally possible under the present system but is actively encouraged by it. We are indeed strongly of the opinion that, if the custody of public funds is entrusted with confidence to these voluntary boards and committees, the confidence will not be abused and the sense of responsibility with which they undertake their work will be increased. We do not believe that the method of direct appointment encourages an irresponsibility which is not shown by elected bodies answerable to the electorate. Indeed in the course of this Enquiry we have been impressed by the sense of responsibility shown by committee members in their discussions. We also maintain that unless the boards and committees are given a substantial measure of financial responsibility it will become increasingly difficult to obtain the services of able men and women for them.

The fact that this proposed system breaks with tradition does not seem to us to be an insuperable difficulty. The present financial system was devised at a time when the activities of the central authority were substantially different and more limited in scope. The central authority has not, until recently, been responsible for the direct operation of public social services : the operation has mainly been in the hands of the Local Authorities which, by reason of their contributions from rate funds, have always had a substantial measure of autonomy. Now the central authority has taken on new and direct responsibilities which were not contemplated when the present financial system was devised. There is indeed every reason that the system should not be regarded as unalterable, and that it should be adapted to meet the new conditions.*

(e) House Committees

When the new hospital service came into operation it became the normal practice of Management Committees to appoint House Committees for the individual hospitals in the group : in the case of a Management Committee responsible for only one hospital House Committees were clearly not necessary except as sub-committees dealing with matters of a largely domestic nature.

*See Note on the Eleventh Report of the Select Committee on Estimates (Appendix II, pages 126-127).

From the start there were, however, variations in practice. Some Management Committees appointed a substantial number of co-opted members. Others appointed House Committees from their own members. Others decided not to appoint House Committees at all. There was similar variation in the powers and duties entrusted to the House Committees that were appointed. Some were given powers of decision; others were given only powers of recommendation. Thus from the start there was no universal policy in the appointment of House Committees or in the delegation of powers and duties to them.

In the hospital service there were, and indeed still are, two schools of thought on this question. Some see the House Committee as an important unit in the administrative pattern; others oppose the extension of "two-tier administration" into "three-tier administration" and see no place for the House Committee in the pattern. Some Management Committees endeavoured to reconcile both schools of thought by giving their House Committees the functions of welfare committees with no administrative responsibilities.

It is understood that when the hospital service started its work some of the House Committees appointed consisted, wholly or mainly, of the members of the former Hospital Boards, and that they tended, perhaps naturally, to conduct their business as before 1948, and to assume powers that they had no longer. It was presumably because of difficulties of this kind that early in 1949 the Ministry asked Boards of Governors and Management Committees for information on their experience of the House Committees in operation.

As a result of these enquiries the Ministry issued Circular R.H.B. (49) 107, as follows:

House Committees

"1. The Minister has now had an opportunity to consider the replies received to the recent letter (94101/2/36) asking for information from Hospital Management Committees and Boards of Governors on the setting up of House Committees, i.e., sub-committees with functions in relation to a hospital or hospitals within a group. It appears from these replies that there are considerable differences in the policy adopted by different Hospital Management Committees and Boards of Governors on the appointment, constitution and functions of House Committees of this kind. The Minister would be glad if all Boards of Governors would now review their present policy in the light of the notes below and if Regional Boards would examine the measures taken by Hospital Management Committees, with a view to bringing the present arrangements into conformity with the following principles. While there will undoubtedly be a need for considerable variation in the detailed application of these principles to meet local circumstances, Boards are asked to ensure that there is no departure from the general policy set out in the next paragraph and that the suggested functions of House Committees set out in paragraph 4 are in no instance exceeded. If existing arrangements conflict with these principles they should be brought into conformity with them as soon as circumstances permit, possibly when new Committees are appointed.

2. *Appointment of House Committees*

The decision whether House Committees should be appointed, and if so whether

for individual hospitals or for sub-groups, must largely depend on the nature of the hospitals or group managed by the Management Committee or the Board of Governors. If a single hospital or a small compact group are concerned, no such Committee may be needed. But the Minister considers that in large or widely scattered groups the appointment of House Committees can do much to stimulate and maintain a lively local interest in the hospital service, to give valuable opportunities for voluntary public work, and to provide a field for recruitment, or a training ground, for future members of Management Committees and Boards of Governors. Under the National Health Service (Regional Hospital Boards, etc.) Regulations, 1947, it is open to Hospital Management Committees and Boards of Governors to appoint sub-committees which include non-members of the Committee or Board; and in this way newcomers to hospital work can be introduced through the medium of the House Committee. He suggests, therefore, that Committees and Boards in charge of large or scattered groups should normally appoint a House Committee either for each hospital in the group or, where more appropriate, for any compact sub-group of hospitals within the group.

3. *Constitution of Committees*

When appointing members, Committees and Boards should consult appropriate local organisations—e.g., Local Authorities, Trades Councils, women's and other voluntary organisations. The size, constitution, term of office and, if so desired, standing orders of House Committees are, under article 4 of the National Health Service (Regional Hospital Boards, etc.) Regulations, 1947 S.R. & O. No. 1298, to be determined by the Management Committee or Board itself. The Minister suggests that appointment might be for the same period as for other sub-committees of the Management Committee, and there is no reason why retiring members of Management Committees and Boards should not remain on or be re-appointed to a House Committee.

4. *Functions of House Committees*

The functions to be performed by House Committees under article 4 of the regulations cited will necessarily vary in accordance with circumstances. As already mentioned the status of a House Committee is, formally, that of a committee of a Board of Governors or sub-committee of a Management Committee. It will therefore be for the parent body—subject, in the case of a Management Committee, to any general policy formulated by the Regional Board—to determine whether (*a*) they will delegate functions to their House Committees, that is, give them final responsibility for decisions in defined spheres; or (*b*) they will make all decisions (or recommendations) of the House Committees subject to confirmation by the parent body; or (*c*) combine the two methods. The Minister wishes, however, to avoid fragmentation of the hospital service by breaking down the two-tier system of administration provided for in the Act into a three-tier system. It therefore seems to him undesirable to confer executive functions on House Committees, i.e., to delegate to them powers of appointing staff, incurring expenditure (other than from "free monies," etc.). The value of House Committees lies rather in the field of overseeing the daily conduct of the hospital and the welfare

of patients and staff, and of making recommendations to the Management Committee or Board of Governors for these bodies to decide. It lies also in the field of acting as a link between the local community and the hospital and providing an opportunity for those interested to take part in hospital work. Accordingly the powers delegated to House Committees should not in any circumstances exceed the following :

(*a*) *General*

(i) Visiting, supervising the *welfare* of patients and staff, and making recommendations to the Management Committee or Board on the day-to-day running of the hospital (but not taking executive action).

(ii) Recommending developments or new policy to the Management Committee or Board.

(*b*) *Financial*

(i) Managing the individual hospital's share of the Management Committee's or Board's "free" money. (House Committees cannot, however, legally accept or hold gifts, etc., under sections 59 (1) and 60. These must be held in the name of the Management Committee or Board of Governors).

(ii) House Committees should not, however, be empowered to incur on their own authority any expenditure from Exchequer funds.

5. *Mental Hospitals*

Where the Management Committee group consists of only one hospital it may still be desirable for the Committee to set up a House Committee to whom they could delegate some of the special functions set out in H.M.C. (48) 4."

Since the issue of this circular those Management Committees which had given any measure of authority for decision, and of financial authority extending beyond the use of "free money," have modified their schemes of delegation. At least one Management Committee has abolished House Committees, feeling that they serve no useful purpose.

We have given this question careful thought, and we believe that the House Committee should be a vitally important unit in the administrative pattern for the hospital service. We feel that in the administration of hospitals there are important decisions which can only be made satisfactorily in the hospital itself by people who are familiar with the detail of the administration and the problems of the hospital concerned. We believe from experience that any institution of this kind flourishes under conditions of relative freedom and declines under remote control, and that the delegation to House Committees of a reasonable measure of responsibility would attract to them the kind of people whom the experience of the past has shown to be of the greatest value to the hospital service—people who will give their time and energies in voluntary service to their own hospital ; such people, through the valuable experience they will gain, will be a fruitful field from which future members of Management Committees and Regional Boards can be chosen. We do not believe that committees which are given the limited functions of welfare committees, with no powers or direct administrative responsibilities, can remain effective for any length of time : the busy men and women whose interest and judgment are needed if the hospitals are to flourish will be unwilling to spare the

time to serve as members, and House Committees will come to consist solely or largely of people who are glad to find ways of occupying their time.

At the same time we recognise that the pattern of group management, on which the new hospital service is based, demands that all the hospitals in the group should, in a sense, be regarded as one hospital rather than as several independent hospitals under one administration. We appreciate that to extend the responsibilities of House Committees might have the effect of fostering a spirit of individualism which would weaken the integration of the group, particularly since loyalty to an individual hospital is almost certainly likely to be stronger than loyalty to the group. The principle of group management is basic to the new hospital service and clearly must be maintained.

It seems to us, therefore, that a careful balance must be preserved. In our view House Committees should be more than welfare committees but should not be in a position to develop their hospitals in isolation. We see no reason why they should not be made responsible for the preparation of estimates for the Management Committee, and then be given authority to undertake the day-to-day administration of their hospitals within the approved estimates, submitting their minutes or reports to the Management Committee at each meeting and, if required, financial statements showing expenditure, incurred to date under each heading of the estimates. In our view their powers should extend only to normal items of expenditure ; extraordinary items and any expenditure over and above the approved estimates should require the special sanction of the Management Committee. We do not suggest that the House Committees should have any responsibility for capital expenditure, although it is to be hoped that they would be fully consulted on all capital items. House Committees should also, in our view, be responsible for the initial stages of the appointment of officers whose duties lie solely in the individual hospital ; it would be reasonable that the dismissal of an officer should rest with the Management Committee.

We recognise that there are many very small hospitals in the hospital service, and it has been suggested that many are too small to justify the appointment of a House Committee, and that it would be impracticable to give any kind of authority to House Committees of such hospitals. We believe that even the smallest hospital justifies the appointment of a House Committee, and it is our experience that most people who will serve on committees are as ready to give their time to committees concerned with small institutions as they are to committees with greater responsibilities. We recognise, however, that most Management Committees would feel that they were not justified in giving to the House Committees of very small hospitals powers and responsibilities as extensive as they would give to the House Committees of the larger hospitals.

We would hope that the members of the Management Committee would serve as members of the House Committees so that the Management Committee was kept in close touch through its members with the day-to-day administration of the hospitals in the group, and was able through them to ensure that such freedom of administration as was allowed to the individual hospitals did not weaken the unity of the group hospital service. We believe that individual freedom is not inconsistent with the maintenance of the group as a unity, and that in this kind of way a reasonable balance of powers and responsibilities could be achieved. Indeed we feel that it should be the exception to have a member of a Management Committee who did not serve as a member of a House Committee in the group. The remaining members of the House Committees would be co-opted members appointed by the Management Committee.

(f) The Teaching Hospitals and Regional Administration

The teaching hospitals are hospitals used for the teaching of undergraduate and post-graduate medical students and for medical research. They work in close association with the medical schools of the universities of which the students are members. Under the National Health Service Act of 1946 there were designated 36 teaching hospital groups (parent hospitals with associated hospitals), of which 24 are in London and 12 are in the provinces. The teaching hospitals combine the functions of teaching with the normal functions of hospitals, although the types of cases admitted to the public wards are to some extent limited by their suitability for teaching purposes.

When the pattern of regional administration for the hospital service was designed it was accepted as a principle that each hospital region should have within it a university medical school and teaching hospital group. In the provinces this makes a clear and coherent pattern, but in London, with the aggregation of teaching hospitals, the pattern is more confusing : the four Metropolitan hospital regions each contain more than one teaching hospital group but must necessarily share one university medical school.

The National Health Service Act provided for the teaching hospital groups to be administered by Boards of Governors, and for these Boards to be independent of the Regional Hospital Boards and responsible direct to the Minister. Furthermore, provision was made for the teaching hospitals to retain, and to have free use of, their endowment funds.

The Act provided for the constitution of the Boards of Governors (Part III of the Third Schedule) as follows :

> "The Board of Governors of a teaching hospital shall consist of a Chairman appointed by the Minister and such number of other members so appointed as the Minister thinks fit, and of those members—
>
> (*a*) not more than one-fifth shall be nominated by the university with which the hospital is associated ;
>
> (*b*) not more than one-fifth shall be nominated by the Regional Hospital Board for the area in which the hospital is situated ;
>
> (*c*) not more than one-fifth shall be nominated by the medical and dental teaching staff of the hospital, and
>
> (*d*) other persons shall be appointed after consultation with such local health authorities and other organisations as appear to the Minister to be concerned, including, in the case of the original members of the Board of Governors of a teaching hospital designated before the appointed day, the governing body of any voluntary hospital comprised or to be comprised in the teaching hospital."

It will be seen from this that there is one striking difference from the method of appointment provided for the Regional Boards : the principle of nomination is applied under (*a*), (*b*) and (*c*). Moreover, if the full number of nominated members is appointed such members will outnumber the members directly appointed by the Minister.

From enquiries made it appears that a typical Board of Governors has one-third of its members drawn from the former governing bodies of hospitals in the group, one-third medical representatives from hospitals in the group, and one-third new lay members representing wide and varied interests, including the "consumer." We have heard

criticism of some of the appointments made by the Minister, including criticism of political bias. We have also been informed that although members are appointed as individuals they tend to regard themselves as representatives of the interests with which they are connected.

The relationship between the Boards of Governors and the Ministry of Health appears, on the whole, to have been successful. We have gained the impression that the Ministry have been prepared to allow the Boards of Governors a greater measure of administrative freedom than they have allowed to the Regional Boards. The relationship between the Ministry and a Board of Governors presents, of course, fewer complications than the relationship between the Ministry and a Regional Hospital Board which has more extensive administrative responsibilities involving considerably greater expenditure. In general the Boards of Governors seem to have been given reasonable freedom in expenditure within the approved estimates. Their possession of endowment funds, many of which are very substantial, has given them a further measure of administrative freedom, 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. Up to the present the teaching hospitals seem to have maintained a relatively independent position.

The relationship between the teaching hospitals and the Regional Boards appears in general to have been less successful. Although the Regional Board areas were defined in such a way as to provide each region with a teaching hospital group and university medical school, there appear as yet to be comparatively few examples of close contact between the Regional Boards, the Boards of Governors and the universities, or of the teaching hospitals being used for the benefit of the regions as a whole. There are examples of teaching hospital medical staff being used as part-time consultants in the regions, but in some regions contact seems to be limited to some overlapping in committee membership and to discussion of matters of common interest and concern in joint committees. It is appreciated that in the Metropolitan regions difficulties may well arise as a result of there being a number of teaching hospitals in each of the regions and of there being a looser connection with the university than exists in the provincial centres.

The function of the teaching hospitals in the regional service does not appear to have been determined. It has for some years been widely discussed. The Dawson Report of 1920 recommended that the hospitals, which the committee proposed should be called "secondary health centres" should "be brought into relation with a teaching hospital having a medical school." The Goodenough Committee, which was set up to consider the position of the medical schools in a comprehensive national health service reported in 1944 as follows:

> "Educational associations can and should be developed between a medical teaching centre and all the major hospitals in a wide area around the centre (i.e., in the centre's "zone of influence"). If these major non-teaching hospitals are linked by means of their specialists with outlying "general practitioner" hospitals there will be a measure of contact between the centre and all hospitals in its zone of influence."

In the United States some experiments have been made, of which perhaps the best-known in this country is that of the Bingham Associates Fund in Boston. In a recent paper on "The Place of the Medical School in the Regionalisation of Hospitals," Dr.

Proger writes : "The role of the medical school hospital center is vital and any regional planning should take this fact into consideration. It is not enough to feel that somehow, as the occasion may arise, a medical school might be utilized. The medical school should be made an integral part of the planning from the outset." The American schemes provide for medical, nursing and professional staff from the teaching hospital to go out into the hospitals in the region to give their advice and help as appropriate, and for the staffs of hospitals in the region to come in to the teaching hospital for refresher training and conferences. This pattern may, or may not, be suitable for application in this country, but it seems to have certain advantages, not least the close association of the general practitioner not only with his local hospital but with the teaching hospital in the region.

It should be pointed out that various practical difficulties arise from extending the influence of the teaching hospitals in the regions. For instance, as the Goodenough Committee pointed out, there must be caution in the use of teaching hospital specialists for part-time consultant service in the field on the grounds that their time is needed essentially for their work in the teaching hospitals, in care of the patients, medical education and research. However, if the principle is accepted, no doubt practical difficulties can be overcome. Failing the acceptance of the principle there seems to be no point in continuing to base the regions on medical schools.

This point is raised because it is closely connected with the controversial question whether the teaching hospitals should continue under relatively independent administration, or whether they should, as in Scotland, come under the jurisdiction of the Regional Boards. Those who advocate the latter course claim that if the teaching hospitals are to become the medical centres of the regions, spreading their influence throughout the regions, they must come under the regional administration. In general, those who are connected with the teaching hospitals would claim that the influence of these hospitals could be extended without any alteration in the present administrative pattern.

It may be that if some scheme on the general lines of the recommendations of the Goodenough Committee and of the experiments in the United States were adopted it might prove to be desirable, or even essential, that the teaching hospitals should work under the regional administration. On the other hand, experience may prove that equally satisfactory results can be achieved under the present administrative pattern. The Goodenough Committee stated that "the individual freedom enjoyed by medical schools in academic matters is an asset that must be fully preserved." In its teaching functions a teaching hospital may be said to be a part of the medical school and thus a part of the university, and it is an accepted principle that the universities should be independent of external control. If this argument is accepted it would seem that the teaching hospitals must remain independent in administration. On the other hand it seems logical that if the teaching hospitals are to be a centre of influence in their regions they should work within the framework of the regional administration.

We feel that it is difficult to make a decison on this point until the function of the teaching hospitals in the regional service is determined. There does not appear to be an immediate and clear answer, and it is our view that consideration should be given by the Ministry, the Boards of Governors and the Regional Boards to the function of the teaching hospitals in the regional service, and that the administrative pattern should then be decided in the light of the functions as determined. In the meantime we feel that no change should be made.

We would regard it as most unfortunate if the teaching hospitals, by reason of their relatively independent position, adopted any kind of exclusive attitude towards the hospital service as a whole. Indeed, we feel that the development of the teaching hospitals' function in the regional service may perhaps best be found by an evolutionary process worked out by experiment and joint discussion, and that opposition might well be avoided entirely if the right approach were made on both sides.

(g) The Committees and Their Officers

In democratic societies the committee has come to be accepted as an essential element in administration. When any new problem arises, or any new service has to be organised, new committees are appointed. We seldom, if ever, pause to consider how many committees there are at work in this country, or how many "man-hours" are expended each year in committee service by men and women throughout the country.

The new hospital service follows tradition in that its administration is entrusted to committees. The committees find it expedient to appoint sub-committees, and so the number of committees grows. There are 36 Boards of Governors of teaching hospitals, 14 Regional Hospital Boards and 378 Hospital Management Committees—a total of 428 principal committees. It would not be over-estimating to assume that on an average each principal committee has five sub-committees, which gives a total of 2,140 sub-committees. To these must be added the House Committees of individual hospitals, and these will double or treble the total. There are probably at least 5,000 to 6,000 committees concerned with the administration of the hospital service and at least 60,000 to 70,000 committee meetings each year. Most of the principal committees consist of 15 to 25 members; sub-committees are generally smaller. It has been found that there are not less than 10,000 men and women who give unpaid service as members of these committees.

It has been suggested to us, as an alternative plan, that it might be of benefit to the service if the example of industry were followed and the administration were undertaken by small boards each containing one or more members who give their services full-time; each of the Regional Boards, Management Committees and Boards of Governors might consist of 10 members, with either a full-time chairman or a full-time managing director who would be both a committee member and an executive officer. The boards and committees would deal with all business, and would not require to have sub-committees. Each hospital would have a small House Committee reporting direct to the Management Committee. Necessarily the Boards and Committees would delegate a substantial amount of authority to their chairmen, managing directors and officers, and Management Committees would delegate responsibilities to House Committees. The chairman, if he gave full-time service, might possibly be paid a salary, following the precedent of government trading undertakings; a managing director certainly would be a paid officer. The other members would presumably remain unpaid.

The advantage of such a plan would seem to be that time would be saved on committee work, since small committees tend to get through their business more rapidly than large committees, and since there would be few, if any, sub-committees, members of small committees would probably feel that they must devote themselves to their work, in attending meetings and in visiting hospitals, more assiduously by reason of their being few in number. A further point made is that whereas in a large committee there is normally an "inner ring" of a few members who take the lead and tend to become an

unofficial executive, in a small committee such a division would be impracticable and unnecessary.

The main disadvantage would be that fewer people would be associated with the administration of the hospital service, and the link between the hospitals and the community might thus be weakened. Furthermore, although the members of the present committees are appointed as individuals and not as representatives, the membership does in fact contain representation of the main interests concerned, and at least some measure of geographical representation. Small committees could not be effectively representative of either.

Only experience would show whether the advantages outweigh the disadvantages. We are inclined to think that one effect would be that the influence of voluntary service would be weakened: if so, we are convinced that increased speed and efficiency would have been bought at too high a cost. At the same time we believe that the present committee system might be improved, and we think that a study should be made of the administration of the nationalised industries, such as the National Coal Board, the British Electricity Authority, the British Gas Board and the Transport Executive, which have broadly followed the industrial pattern, with a view to considering whether their working experience has any light to throw on this question.

A committee is not an executive body; it requires an administrative staff to translate its decisions into action. The effectiveness of a committee therefore depends to a considerable extent on the efficiency of its staff.

Each Regional Board and Management Committee appoints its own staff. The officers are directly responsible to the boards and committees and are not civil servants. The staffs of the Regional Boards are not therefore in the position of having to accept instructions from officers of the Ministry of Health; similarly the staffs of the Management Committees, although technically employed and paid by the Regional Boards, are in fact responsible to their Committees and are not in the position of having to accept instructions from officers of the Boards. This is an important factor in a scheme which provides for each of these bodies to have "a real measure of responsibility within their own sphere." At the same time, this scheme of independent appointment does not provide for the individual officer the protection which he would have as a civil servant, and it puts him in the position of holding his appointment at the will of the employing Board or Committee. It appears to be doubtful whether adequate protection for the officers is yet provided. We feel that there should be an official procedure which provides the opportunity for appeal to a disinterested body. The Whitley Council for the Health Service is as yet new; in time it will no doubt ensure protection for all hospital staffs and secure the establishment of the necessary machinery.*

Successful working of the administration depends on successful personal relations among officers of the Ministry, the Regional Boards and the Management Committees, and on the effective development of team-work. We commend the practice of the Ministry of holding conferences of chief officers of the Boards with their own senior officers, although we are of opinion that there is some disadvantage in such conferences being arranged for the various groups of chief officers separately since the holding of separate conferences for Secretaries, Treasurers, etc., is liable to encourage exclusive administrative channels. We feel that all possible steps should be taken to bring the various chief officers of all kinds together believing that this would contribute to success-

*See Note on the Eleventh Report of the Select Committee on Estimates (Appendix II, pages 126-127).

ful team-work. Similarly we commend the Boards which hold conferences of officers of the Management Committees with their own officers. Personal contacts of this kind will straighten out administrative difficulties far more effectively than any amount of correspondence.

The relationship of the committees to their officers is of some importance. In our view the relationship is satisfactory where a committee has, and shows, confidence in its officers but makes its own decisions. The two extremes, committees dominated by their officers and officers dominated by their committees, are equally unsatisfactory. Successful relationships are based on mutual confidence, and take time to establish.

The working relationship between the chairman of a committee and the committee's chief officers can make or mar efficient administration. The chairman should be available frequently for consultation, and, when necessary, he should be ready to take responsibility for decisions which he makes on behalf of the committee. He is free to take an independent line if he chooses to do so, and, if he objects to a ruling of higher authority, he can carry his objection to the point of resignation. A chief officer can never have quite the same measure of independence, and he may well need from time to time the support of his chairman.

Of equal importance is the relationship between officers, their colleagues and staffs. In the course of our investigations we have become aware of certain tensions existing between senior officers which seem liable to affect the work of some of the boards and committees. We believe that these are due mainly to the fact that relative functions and responsibilities have not been clearly defined. From our experience of administration in various kinds of organisations we would say that it is most important that there should be clear definition and division of functions, and that this is particularly important in any organisation which, like the hospital service, contains among its administrative staff both lay administrators and technical experts. We believe that the functions of the administrators and the technical experts should not overlap, and that as far as possible each should have responsibilities clearly within his own field of work. In a new service such difficulties are likely to arise, but they cannot be allowed to continue. There are certain factors which tend to cause friction even among people of goodwill. If the causes of friction are removed, continued failure of functional relationships must then be attributed to lack of administrative competence.

In the past Secretaries of hospitals frequently served as House Governors. They knew all the hospital staff, medical, nursing and lay, personally, and dealt with all matters of day-to-day administration in the hospital. The new administrative pattern gives most Secretaries of Management Committees responsibility for a group of hospitals, and this makes it difficult, if not impossible, for them to act as House Governors. If they chose to serve one of the hospitals in the group in this way there might well be criticism of favouritism, however unjustified. We regard the function of House Governor as important, and we feel that it is closely connected with the functions of the House Committee. At present most hospitals have Administrative Officers, who are members of the Management Committee's staff working in the hospitals, but the scale of salaries for such appointments is so low that at best a hospital can normally only expect to have as its Administrative Officer a comparative new-comer to hospital administration. We have already expressed our view that the House Committee of an individual hospital should be regarded as an important unit in the administration of the hospital service, and, in line with this, we are of opinion that the scale of salaries for these appointments should

be high enough to attract men and women to whom real administrative responsibility can be entrusted, and who are sufficiently experienced to act as Secretaries to the House Committees and House Governors of the hospitals.

A successful hospital administrator needs a high degree of administrative ability, a sound training in hospital administration, and a mastery of the art of human relations. A good hospital is human and efficient, and it cannot be such without a human and efficient administration. We commend the Institute of Hospital Administrators for its endeavour to maintain a high standard in the profession and to raise the standard even higher.

The training of the future hospital administrators, and the refresher training of men and women already in the profession, are very important tasks, and we believe that the Hospital Administrative Staff College that has recently been provided by King Edward's Hospital Fund for London has a great opportunity and responsibility in undertaking this work.

We feel that recruitment to the profession needs to be studied. We understand that hospital administration has only recently been recognised as a profession in its own right, and we feel that the Ministry of Labour, the universities and their appointments boards, and other bodies of this kind, should be given full information about the training available and the prospects which the profession offers to able men and women. We believe that this is an urgent matter, and we hope that immediate attention will be given to it by the Ministry, the Institute of Hospital Administrators and the Hospital Administrative Staff College.

(h) The Contribution of Voluntary Service

In this chapter we have examined the administration of the hospital service in some detail with a view to determining whether voluntary service has a valuable and important contribution to make to hospital administration, or whether it is a survival from the past which is inappropriate to modern conditions and should disappear. The views which we have expressed so far have been based on the assumption that the administrative structure of the hospital service provided by the National Health Service Act of 1946 will remain substantially as at present, and that the partnership between the State and voluntary service will continue. We feel that to conclude this chapter we should try to assess whether in general the partnership appears to be successful enough to justify its continuance, or whether it should be accepted that the experiment has failed.

Administration of public services by committees of unpaid men and women has of course been tested over many years in local government, and there is nothing that is new in this. What is new is the form of relationship between the committees and the central authority. There is no direct parallel with local government, since members of Local Authorities, although unpaid and thus giving voluntary service, are elected representatives of their constituents, and since the Local Authorities are semi-independent public bodies which are substantially financed from local rates. There are therefore two elements in the relationship between Local Authorities and the central authority which do not exist in the administration of the hospital service.

We believe that on the whole the partnership has made a successful start, successful enough to justify its continuance. The greatest danger to its continued success appears to us to be the tendency of the central authority to regard the voluntary boards and committees not as partners with them in the administration of the service but as their unpaid servants. The relationship of partnership, that of principal and agent, is very

different from the relationship of master and servant, and we are confident that the administration can only be effective if the voluntary partners are not only allowed to have, but are encouraged to have, wills of their own and a substantial measure of individual authority. This was the original concept on which the scheme was based.

We appreciate that this raises difficult problems. It is by no means easy to find the way of reconciling central direction with decentralised executive authority, and it is not surprising, in the difficult times through which this country is passing, that there has been a tendency to strengthen the former and weaken the latter. The Minister is responsible to Parliament, and has to face parliamentary criticism. To give his voluntary agents substantial authority is to take a risk that the authority will be abused, possibly with the best of intentions. His Ministry will feel that it is their duty to protect their Minister, and will tend to avoid such risks. Yet, in our view, it is only by taking these risks that the scheme will succeed. We believe that if the original concept on which the scheme was based vanishes something of essential value will be lost.

The Cave Committee in 1921 argued that the humanity of hospitals depended on the survival of the voluntary hospitals and would disappear if hospitals were provided by the State. We would not accept this view, but we do believe that the retention of voluntary service in hospital administration is vitally important. That the service should be a national service under central direction is clearly right ; that it should be entirely controlled by the central authority seems to us wrong, and we feel that the blending of central direction with voluntary executive action is logical and intelligent. Through the voluntary boards and committees the hospitals can continue to be closely linked with the communities which they serve, and the people can continue to regard them as "our hospitals." Without this essentially personal link the hospitals would, in our view, tend to become purely detached technological institutions with an entirely utilitarian function. As such they could be highly efficient but they would lose their humanity.

It is difficult to analyse the contribution that voluntary service can make in administration. Paid officers could make all the decisions that are made by voluntary committees and much time would be saved. Perhaps it is in the admixture of different points of view expressed by people who are personally disinterested that its strength lies. A committee can provide a consensus of opinion, perspective and objectivity, all of which are of value. It also provides a safeguard against the ill-effects of bureaucratic control : this could become increasingly important since experience seems to indicate that an increase in public administration tends to produce an officiousness in minor office and some decline in courtesy to the public.

John Stuart Mill gave an impressive warning in his essay "On Liberty" which was written nearly a hundred years ago :

> "If the roads, the railways, the banks, the insurance offices, the great joint-stock companies, the universities, and the public charities were all of them branches of the government ; if, in addition, the municipal corporations and local boards, with all that now devolves on them, became departments of the central administration ; if the employees of all these different enterprises were appointed and paid by the government, and looked to the government for every rise in life ; not all the freedom of the press and popular constitution of the legislature would make this or any other country free otherwise than in name."

Even if this is now considered to be exaggeration, it would be well that our statesmen and civil servants should heed the warning.

It is not necessarily a question of choice between two systems. There is room for experiment, and it may be that this new pattern of public administration that is being tried for the hospital service will point the way to future development. It cannot be finally judged on an experience of only three years, and we would like to see it continued, but we think it important that it should be given the chance of showing what can be achieved by a real partnership. As Dr. T. F. Fox said in his Croonian Lecture of 1951 : "The coercive use of State power directly through a homogeneous and subservient bureaucracy and police force is one thing : its benevolent use indirectly through a variety of autonomous bodies, ranging from universities to women's institutes, may be quite another." The results of the present experiment may be of great significance.

The major problem which society faces in our time is how to secure freedom for individual development within an ordered structure under central direction. The major problem of the hospital service is the same, how to secure freedom for the individual hospital within the ordered structure of a national service under central direction. The solution to this problem has not yet been found, and may well not be found for some time; perhaps it will emerge by evolutionary process as the service grows. Experience must point the way, and experiment must feel the way. Of one thing, however, we are sure ; without the contribution of men and women who will give their services readily and freely, and who seek for no reward, the vital power on which the essential humanity of the hospitals ultimately depends will be lost, and we shall all be the poorer for it.

PART III

CHAPTER V

VOLUNTARY SERVICE TO THE SICK AND INFIRM

(a) The Present Need for Voluntary Service

Many people think that with the "nationalisation" of the hospital service the voluntary worker is no longer needed. In our investigations we set out to learn whether this was true or not. We have found that in 1948, when the National Health Service Act came into operation and all but a few hospitals were transferred to the State, there appears to have been an immediate decline in the amount of voluntary personal service given to hospitals, and that some voluntary societies associated with hospitals, particularly local societies such as Ladies Leagues, were disbanded. Within a very short time, however, it was seen that the need for such service was as great as ever, and voluntary service revived to its former strength. Soon it came to be realised by those most closely concerned with medical-social work that the need was greater than ever before. Voluntary workers were needed in all hospitals, not only in the former voluntary hospitals. New services, such as trolley-shops and out-patient canteens, were needed. The problem of old people's welfare became a major social problem, and voluntary service was needed to tackle it. The shortage of hospital beds was serious, and everything possible had to be done to care for the aged and infirm and convalescents in their homes. New demands, both national and local, were made on voluntary societies, and it is true to say that at the present time, although there is a national health service financed almost entirely from public funds, there is more voluntary service given to the sick and infirm than ever before.

Even now it is not generally realised that the need for voluntary service has increased. The supply of workers is not as great as is needed, and money to finance the voluntary societies is difficult to get. Expansion will continue as the present services are extended and new services are started. Hospitals which have never had voluntary workers are coming to discover what the voluntary societies can do to help them, and the demand steadily increases. The voluntary societies are presented with a challenge that is greater than any in their history.

The voluntary societies in this country are a typically English product. "The English have a genius for voluntary co-operation . . . It is hard to think of any object for which there was not an association of English men and women"—so writes Arthur Bryant in "The Age of Elegance" of the years that followed the defeat of Napoleon. We have grown accustomed to this feature of English life, and to-day few realise how much voluntary service is given in this country, and how much of the social progress in the last hundred years has been due to the voluntary societies. Not only does this country owe them an immense debt, but millions of men, women and children owe them a personal debt for help received as individuals. The voluntary societies seek publicity only so far as publicity is needed to raise money ; they are more interested in the work that they do

than in receiving credit for it, and their modesty is a part of their strength. It is a tribute to them that they are accepted as a familiar feature of English life, and that it is generally taken for granted that appeals for help in real need will never be rejected.

True to the English way of life there has never been any set pattern of voluntary society, and the history of the societies is full of variety and individuality. Often local genius and initiative have met local needs. Sometimes a lead given in one place has been followed in others ; sometimes, as a result of this, expansion has led to the formation of a national society.

The care of the sick and infirm has always attracted voluntary service, and many voluntary societies have been founded for this purpose. In our time the greatest amount of work in this field is undertaken by the St. John Ambulance Brigade and the British Red Cross Society, and by the Women's Voluntary Services which, though not a voluntary society, is composed very largely of voluntary workers. The St. John Ambulance Brigade was established in 1877 by the English Knights of the Order of St. John of Jerusalem, an Order founded in the 11th century. The British Red Cross Society, which is affiliated to the International Red Cross, is an incorporated body with a charter granted in 1908. The Women's Voluntary Services were established in 1938 under the threat of war, to help to meet the human emergencies which war would bring, and quickly expanded their activities into civilian welfare. Through these organisations a large amount of voluntary personal service is given to the sick and infirm, to the young and the old.

In addition to these there are many voluntary societies active in this field. Some are national bodies giving this kind of service as part of a wide range of voluntary social activity : the Churches and Church Societies, Councils of Social Service, Toc H and the Rotary International are examples. Others are national societies dealing with specialised parts of the field such as, to mention only a few, the Central Council for the Care of Cripples, the Invalid Children's Aid Association, the National Association for Mental Health, the Mental After-Care Association, the National Association for the Prevention of Tuberculosis, the Friends of the Poor, the Welfare Department of the Jewish Board of Guardians, the National Institute for the Blind, the National Old People's Welfare Committee and the National Corporation for the Care of Old People. Everywhere, too, there are local bodies founded to meet special local needs, such as Hospital Linen Leagues or Ladies Leagues, Leagues of Hospital Friends, Convalescent Homes Associations, and many others.

The history of such voluntary societies is full of interest. Many of them were started in the latter part of the 19th century in the poorer districts of London and in provincial cities and towns with the aim of helping those who were suffering—the cripples, the blind, the deaf and others—in their particular locality. They appealed for voluntary workers with enough time to devote to the work, and to the general public for funds to make the work possible. The story of these societies is a record of generosity of both time and money. In the early part of the present century their work greatly expanded, and the societies began to get a wider picture of potential achievement. They began to think of undertaking research, of setting up homes, of experimenting with new methods of instruction, and of widening their organisations to give greater service to more of the people whom it was their aim to help. Always, too, they had to educate the public to the point of giving the financial help on which the work depended. They began to employ

paid staff who were needed to take over the task of administration which had become formidable, and as a result the majority of the voluntary societies at the present day employ paid professional staff who work side by side with a much greater number of voluntary workers. With their expanding organisation and their increasing efficiency produced by growing experience, the voluntary societies were more and more used by the Local Authorities who were entrusted with increasing responsibilities in the field of social welfare.

By the end of the first quarter of the century many of the voluntary societies which had been founded as purely local societies had become constituent groups of national federations and associations, sharing a common objective and a common policy with other societies in the field, but preserving an independent existence. This development occurred as a result of the growing awareness of the need for co-ordination of voluntary effort. In the wider field of social service the National Council of Social Service had been set up for this purpose. This kind of co-ordination made it possible for voluntary service to be used on a national scale by the State, and as a result many voluntary societies began to be used by the Government as agents, either direct or through the Local Authorities. Their services were repaid by grant-aid, but they preserved their independence and their freedom to determine their policy and control their own affairs. The National Health Service Act provides for a continuance of this form of agency, and the Ministry of Health has continuously emphasised that the voluntary societies have a vitally important contribution to make in the new national health service.

The hospital has always been a focal point for much voluntary service. The voluntary hospital was not only "supported by voluntary contributions" but was a centre for personal service, and the raising of money for the voluntary hospitals has in the past involved the organisation and running of countless hospital weeks, flag-days, fêtes, dances, concerts and whist-drives. Such activities helped to form a strong link between the voluntary hospital and the community that it served, and the term "our hospital" was in common use. This tradition of voluntary service applied almost exclusively to the voluntary hospitals. The poor-law infirmaries, and later the municipal hospitals, hardly experienced it. These hospitals being financed from public funds did not have the same appeal as the voluntary hospital; the raising of money and the giving of personal service seem to have been closely associated.

In these circumstances it was reasonable to expect that, on the introduction of the new hospital service and the transfer of all but a few of the voluntary hospitals to the State, voluntary personal service would disappear or at least substantially decline. It has, therefore, been encouraging for us to find voluntary workers in action throughout the country, and everywhere stressing the urgent need for more volunteers to join them. We believe that there are many people who will readily give their services if they realise that voluntary service is still needed for the patient in the hospital, and for the sick and infirm in their own homes. With this in view, we have surveyed the field as extensively as possible in a short time, and in this chapter we endeavour to show something of the work that is being done and something of what still needs to be done. We are aware that our picture is incomplete—such is the variety of the pattern that it would need a nation-wide survey to present the complete picture—but we hope that what we give will be taken as a fair sample and no more. If by making known something of what is being done we should help in a small way to increase the contribution of voluntary personal service in the care of the sick, our work will be of ultimate benefit.

(b) Voluntary Service in Action

(i) Activity in the Hospitals

In the course of this Enquiry we have seen or heard of voluntary work of many different kinds in hospitals. We believe that a report on this work may be of value to people who are ready to give their services but are unaware of the kind of work with which they could help ; to the authorities of hospitals in which there is at present little or no voluntary service who may well be unaware of what the voluntary societies are able to offer ; and to the voluntary societies who are always glad to learn of the success of new activities and to undertake pioneer work themselves.

The help that can be given to a hospital by voluntary workers varies according to the type of hospital. In general hospitals, which are now commonly called "hospitals for the acute sick," the opportunities for voluntary service are considerable ; in hospitals for the chronic sick the opportunities, if somewhat different, are as great or even greater ; in mental hospitals the possibilities appear to be more limited ; in infectious diseases hospitals the voluntary worker cannot be admitted to the wards. Hospitals do not, of course, always fall into these categories, and there are many hospitals which admit both "short-stay" and "long-stay" patients, but for convenience we have analysed the results of our enquiries under the three main categories—hospitals for the acute sick, hospitals for the chronic sick and mental hospitals.

Voluntary Work in Hospitals for the Acute Sick

Hospitals for the acute sick range in size from small cottage hospitals with 20 or fewer beds to large hospitals with 500 to 700 beds, and occasionally more. Many of these hospitals also have out-patient departments. Most of the patients are seriously ill, or are in the earlier stages of recovery from illness or an operation ; with the shortage of hospital beds patients are discharged as soon as hospital treatment ceases to be absolutely necessary, and there is a constant "turn-over" of patients as beds are emptied and re-occupied.

In some hospitals voluntary workers, who are mainly members of the St. John Ambulance Brigade and the British Red Cross Society, serve as auxiliary nurses. With few exceptions they are not trained nurses, but their training in first-aid and auxiliary nursing fits them to act as assistant nurses with skill and competence and in the shortage of trained nurses their help is of great value. Naturally in their work they come under the direction of the matron and ward sisters. Auxiliary nurses help with lifting patients, bed-making, bed-pans, etc., and with such general nursing as they are competent to undertake.

Other volunteers serve as ward-orderlies or general orderlies. In every ward there are a number of quite simple things to be done which need not be done by trained nurses. Voluntary workers can keep patients' lockers tidy, bring fresh drinking water, arrange flowers, take round newspapers and magazines, and generally make the patients comfortable. They can also help the ward sister by fetching things for her or taking messages, and do such washing-up as is necessary for the ward. There is always sewing to be done, and swabs and bandages have to be made. In many hospitals voluntary workers repair hospital linen and patients' clothing. There is a special need for help of this kind in maternity wards and children's wards. Help with the serving of meals to the patients is usually welcomed.

The voluntary worker can also help in another capacity, as a person coming in to the hospital from outside. A hospital is an artificial environment, and the patient is cut off from normal life outside. The voluntary worker brings something of the outside world into the hospital, and this is often of great benefit not only to the patients but also to the hospital staff.

In many hospitals volunteers visit patients who have few or no visitors otherwise. Such visits, if made by the right kinds of people, are usually much appreciated. Visitors who adopt a patronising approach, or who show by their manner that they are seeking to "do good," are unsuitable, as are people who talk too much and people who have nothing to talk about. Often regular visits have started with an offer of personal help with shopping or messages, or with letter-writing. In sea-port towns and certain other places visitors who can speak foreign languages are particularly useful. Visits will normally be made during visiting-hours, or at such other times as the hospital staff may approve, so that there can be no question of the visitor staying too long or getting in the way. It is of real importance that the visitors should be people in whom the professional staff can have full confidence so that anything in the nature of friction is completely avoided, even when, as occasionally happens, the visitor has to listen to complaints and grievances aired by a patient.

Some patients need technical advice, such as advice on legal matters or financial matters, and in some hospitals there are voluntary visitors, often Rotarians, who are qualified to give such advice. Such visitors can be of great help to almoners, whose technical knowledge of such matters may be limited. Often advice and help can be given on less technical matters, such as worries about rations for the family while the mother is away from home, or difficulties about maintaining hire-purchase payments. Usually the volunteer can have these problems dealt with by the voluntary society of which he or she is a member, or by a more appropriate society ; sometimes the problem ceases to be a problem when it is discussed.

A comparatively new form of voluntary service in the hospital is the trolley-shop. Voluntary workers take round the wards a shop-on-wheels and sell articles to the patients. It is satisfying to many patients to find that they are able to buy things for themselves, and even if the patient buys nothing the visit of the trolley-shop provides an interest in a dull day.

Library services are provided in many hospitals by the St. John and Red Cross Hospital Library. These two societies work this service jointly, and not only supply the books but, for many hospitals, provide volunteer librarians. Until recently this service was provided for the nominal charge of £2 2s. od. per hospital per year, but in 1950 the charges had to be substantially increased. This library service was started originally for military hospitals, but was extended to civilian hospitals during the recent war. After the war the service to civilian hospitals continued, but it became apparent that the available funds could not maintain the extended service indefinitely, so the two societies offered to continue the service to civilian hospitals at a charge of 5s. od. per occupied bed per year. Some hospitals have their own libraries staffed by volunteers ; others use the local Public Library service. In many places voluntary workers help the hospital library by rebinding worn books.

Many patients receive comfort and help from visits of clergy and ministers, and in many hospitals short services are held in the wards. Carol services are particularly popular at Christmas. At Christmas most hospitals are gay with decorations ; often

voluntary workers provide the decorations, or help to provide them, and join with the hospital staff in putting them up in the wards. There are often entertainments given by volunteers, and particular trouble is taken in children's hospitals and children's wards. Volunteers come into hospitals to play with the children and read to them, and help to keep them as happy as possible in such conditions. We have been reminded that helpers in children's wards should not over-excite the children or stay too long.

Much help can be given in out-patient departments. People who attend infrequently may well find the experience confusing and alarming. The friendly help of receptionists who will answer their questions and guide them to the appropriate specialist departments will lessen their fears and will save the time of a hard-working professional staff. A good many hospitals have an appointment system for out-patients, but it does not always work effectively owing to people arriving late or not coming at all. They therefore tend to give the same appointment time to a number of patients so that the doctors will not be kept waiting. If all the patients come, some of them may have to wait for a long time. Voluntary workers can see that they are comfortably seated—indeed some voluntary societies and local groups have provided comfortable chairs and sofas for out-patients waiting-rooms—and can offer them newspapers and magazines. A common feature now in out-patient departments is a canteen manned by a voluntary staff—a service which in some isolated hospitals is extended to patients' visitors—which serves refreshments at small charges throughout the sessions. In many hospitals we have seen and heard how greatly this service is appreciated. Naturally conditions vary from one hospital to another, and activities which may be possible and effective in one hospital may be impracticable in another. We have, however, been greatly impressed by the ingenuity in improvisation shown by voluntary workers and hospital staffs when conditions are difficult, particularly in the provision of out-patient canteens which require a fair amount of space in places where space is usually limited.

A special service of great value to the hospitals is the Blood Transfusion Service, which is now organised by the Regional Hospital Boards, except in London where the Greater London Blood Transfusion Service, under the management of an executive committee representative of the British Red Cross Society and the Voluntary Blood Donors Association, has been allowed to continue to operate the service. For this service two kinds of volunteers are enlisted—those who will give their blood and those who will assist with the work at the Blood Transfusion Centres. We have been greatly impressed by the readiness of volunteers to give their blood, and by the keenness which they show in recruiting others. The doctor in charge is normally assisted by qualified members of St. John Ambulance Brigade and the British Red Cross Society, but the help of other voluntary workers is needed also. The Women's Voluntary Services give the following list of voluntary services needed in connection with Blood Transfusion Centres: recruiting donors, publicity, enrolment, preparing for the sessions, assisting the mobile units, serving meals to teams, serving tea to donors, and providing clerical assistance. The organisation is a good example of the way in which professional staff and volunteers can work effectively together in providing a particular service. Efficiency is specially important since if the confidence of the public were to be shaken by anything which had the appearance of inefficiency the supply of donors for this essential service would decline. The voluntary workers share with the professional staff the responsibility of maintaining a high standard of work, and the steady stream of donors is a measure of their success.

No record of voluntary service in hospitals for the acute sick would be complete without a mention of the voluntary service given by members of the professional hospital staff. Many people can speak from experience of medical, medical auxiliary, nursing and lay staff who sacrifice precious off-duty time for the welfare of patients. We were particularly interested to hear that in certain hospitals in London it has for many years been a tradition that wives of members of the hospital staff should give their services voluntarily in patients' welfare, a tradition that is probably not exclusive to London. We believe that, at a time when there appears to be a prevalent attitude to work that demands set hours and overtime pay, such examples help to keep alive that spirit of service which has inspired the care of the sick for hundreds of years.

Voluntary Work in Hospitals for the Chronic Sick

The kind of voluntary work required in hospitals for the chronic sick differs in some respects from that required in hospitals for the acute sick. The patients are "long-stay" patients and for most of them the hospital has become their permanent home. Many, although in need of hospital care and treatment, are not seriously ill ; some are bed-ridden but many are not. In the tuberculosis hospitals and sanatoria there are patients of all ages ; in the general chronic sick hospitals most of the patients are old people, but there are, tragically, a few younger people there also.

Almost all the chronic sick hospitals were until 1948 under the Local Authorities and, except for the tuberculosis hospitals and sanatoria, were originally provided under the Poor Law. Many of these hospitals have dismal and depressing buildings with the flavour of the workhouse about them. Until 1929 they were administered by the Boards of Guardians. The Local Government Act of 1929 transferred them to the Local Authorities, but there was little time for them to improve the conditions before war broke out, and many remained Public Assistance Institutions. As a result of this these hospitals have, in the main, no tradition of voluntary service such as was common in the voluntary hospitals. Moreover, in the course of our investigations we have found that some people who have worked in these hospitals for many years have little idea of what service is given in the former voluntary hospitals, and what the voluntary societies are ready to do for them.

All the services that are given in the hospitals for the acute sick are available to the chronic sick hospitals. These include auxiliary nursing, orderly duties in the wards, sewing, help with serving meals, visiting, shopping for patients, legal and financial advice, trolley-shops, library services, and entertainments ; only the services to out-patients would find no place in the chronic sick hospitals. In addition there are other services which are particularly appropriate for this type of patient. Voluntary workers can be found to read to patients—a service which is specially valued by the blind—to help to feed patients who cannot easily feed themselves, to push wheel-chairs in the hospital and outside, to accompany those who can walk, to take patients to the cinema or into the countryside, to play games with them and to undertake simple diversional therapy. All these services, and others of the kind, can be provided by St. John Ambulance Brigade, the British Red Cross Society and the Women's Voluntary Services, and often by local societies or groups as well. In many places help is given also by the Rotary Clubs, which have not only given personal service in the hospitals but have also provided wireless installations, illuminated sticks for the blind and extra amenities of

various kinds. There is a great wealth of voluntary service provided in a few chronic sick hospitals which could be extended to all these hospitals if it is wanted.

We have the impression that in some of these hospitals which have not been used to having voluntary service the hospital staff seem to be apprehensive that the voluntary workers will bring new problems, that they will not be easy to handle, that they will introduce an element of patronage, and that they will come to see what goes on in the hospital and to criticise. This attitude of mind is easy to understand, but we are confident that with the right approach by the voluntary societies it will in a short time disappear. It must be realised that in many of these hospitals the conditions are bad and may well disturb the voluntary worker who is accustomed to the much better conditions in most of the hospitals for the acute sick. There is also much that is distressing to the visitor which no excellence of nursing or of general care can avoid. Hospital staffs may well feel that the outside lay-visitor will regard these things as a reflection on their abilities and standards, and may tend to be on the defensive. We are sure, however, that if voluntary workers are chosen with care, and are specially trained for work in these hospitals, they will quickly gain the confidence of the hospital staffs.

The life of an old man or woman in a chronic sick hospital can be distressingly tedious. Hospital routine makes little allowance for individuality in habits and is the same day by day and week by week. To some old people time must pass very slowly. One old man said, "I don't know whether we are being kept alive longer or whether it just seems longer." Old people are in fact being kept alive longer as a result of improvements in medical knowledge and treatment, and it seems to us a matter of concern that in their latter years they should have interest and pleasure in living. Because of this we think that voluntary visitors should be found in every chronic sick hospital, and we are inclined to think that voluntary societies should make this a central feature of their activities. Old people like to see young life and to hear about local events, but also welcome visitors who are nearer their own age. The garrulous visitor will not be welcomed ; too much talk is tiring. Companionship from outside is what is often wanted. Most of the voluntary service given in hospitals is given by women ; for visiting men are needed as well as women. In many chronic sick hospitals men patients are surrounded by women. They see women nurses and women cleaners every day, and most of the relations who visit them are women since visiting hours are normally during working hours. Almost the only men they see are their fellow-patients and a few doctors. We are sure that men visitors to the wards will be specially welcome. It will not be easy to arrange for men visitors, since most volunteers will only be able to visit in the evenings and old people normally go to bed early, but discussion with the hospital staff may find ways of overcoming this difficulty.

We have come to appreciate the importance in chronic sick hospitals of small amenities for the patients. Material conditions need to be good, and the smallest improvement is immensely appreciated. We have learned also how much it means to old people in these hospitals to have small presents on their birthdays and at Christmas, the more so if they are personal presents addressed to them by name. There is also a child-like delight in having a small bag of sweets or a little tobacco on an outing. Little touches like this can give pleasure far in excess of their cost.

There have been great advances in geriatric work and it is now the aim of geriatrists to equip as many patients as possible to leave the hospital and to live a normal life outside in the care of relations and friends, and to provide as full and rich a life as possible for

those who must stay in hospital. Some valuable experimental work is being undertaken, and in Bedford we were interested to see something of the work of a geriatric unit which made full use of voluntary service. The doctor in charge worked closely with the almoner, whom he described as his "eyes and ears in the homes," and the almoner worked with a committee that was representative of the voluntary societies and local groups that were active in the town. A link with the local authority was obtained through the mayor who was chairman of this committee. The result of the work being undertaken was apparent in the chronic sick hospitals and wards, and in hostels for old people. There was a bright and cheerful atmosphere and plenty of lively activity. One building was reserved for a "Darby and Joan" club which was used every afternoon. A trolley-shop served all the hospitals and wards, and the various voluntary societies and groups arranged between them for visiting, outings, entertainments and diversional therapy. In this town the home-help scheme is organised by the Women's Voluntary Services on behalf of the Local Authority, and there is no separation of after-care from the other work of the geriatric unit.

This seemed to us to be a good example, of which doubtless there are a few others, of what can be achieved by an effective combination of professional and voluntary effort. Each voluntary society and local group works closely with the others, and we felt that the individuality of each society and group was strengthened rather than weakened through each making an individual contribution to a combined effort. We also came to realise that the wide range of work on which this experiment was based could not have been undertaken by the professional staff alone, without the diversity which the voluntary societies and groups could offer. The results already achieved were a noticeable contrast to the death in life to which some old people seem to be committed.

We appreciate that such experimental geriatric work cannot be undertaken everywhere, but we feel that in the ordinary chronic sick hospital there are things that can be done to make life more cheerful and interesting for the patients who are infirm rather than ill. The chronic sick hospital, perhaps more than any other kind of hospital, calls for imagination and enterprise in its administration, and voluntary helpers who have either of these qualities should be particularly appreciated.

In some hospitals patients are employed on light duties as long as they are able to work : in one such hospital we found an old man of eighty, who had been in the hospital ever since he came as a foundling at two years of age, happily undertaking duties which earned him the title of "farm-bailiff." Old people who can make things with their hands get far more satisfaction from doing so if they can sell what they have made, and in some places voluntary societies undertake the sale of articles made in a number of hospitals.

There is a big difference between the ill and the infirm, but unfortunately in many hospitals it does not seem possible to arrange for them to be in separate wards. Where there are patients who are seriously ill, the wards must be kept quiet. Old people who are not ill, but are merely infirm, like to be merry and with the help of voluntary workers there can be life and gaiety in the wards. One matron has told us that the most urgent need in her hospital was for quiet small rooms where old patients who were critically ill could be taken to die in peace and privacy. With such conditions the wards could be bright and cheerful and visitors would feel that they could talk freely and encourage liveliness. Where there is such an atmosphere life seems worth living and old people are encouraged to return to life outside ; where there is an atmosphere of death, life must

seem to be without hope or future. It is tragic to see old people passing their latter years in the shadow of death, seeing their fellows in the ward die one by one and awaiting their turn ; it is even more tragic to see young, or comparatively young, people with incurable illness confined to the company of old people, often in somewhat unattractive conditions, for perhaps many years of life.

The problem of the young chronic sick has received less attention and less publicity than the problem of old people's welfare. Many could contribute to the community, despite their handicaps, if they were given a chance to do so ; the brain can keep alert even if the body is imprisoned by paralysis or arthritis. They need special care and personal interest, and perhaps a visitor each who can give individual friendship and help over a long period. Voluntary societies might well find ways in which these young invalids could make a real contribution and do useful work for their fellows within the limits imposed by their disabilities.

The tuberculosis hospitals and sanatoria present a special problem of their own. The process of treatment is long drawn-out and wearisome, and this often results in boredom and depression. Interest in life is a powerful antidote. This provides a great opportunity for voluntary service with a wide range of activities and interests to offer. Art and crafts have a particular value, as has been shown by the work of Adrian Hill at King Edward VII's Sanatorium at Midhurst, and by many Art Therapists who have received inspiration and guidance from him. Occupational Therapists are now employed at many hospitals, but there is much that voluntary workers can do. Diversional therapy of many kinds is provided by voluntary workers who are trained for the purpose. The National Association for the Prevention of Tuberculosis is active in this field of work, and many voluntary societies and local groups make their own contribution.

Visitors are always welcome, but they should be people who understand the special nature of their task. The risk of infection is considered to be slight, but all precautions are taken and young voluntary workers are not used for regular work.

A most enterprising voluntary effort for the benefit of tuberculosis patients that we have seen is an organisation called the "Friends of Kelling," in Norfolk, which sets out "to mobilise, encourage, foster and maintain the interest of the public in the patients of Kelling Sanatoria and the support of the work of the Sanatoria by voluntary service," and "to provide a link between the Kelling Sanatoria and the community they serve." The organisation was founded in 1948 by three men patients who left the sanatorium at about the same time. They felt that the isolation of life in a sanatorium was increased at Kelling by the sanatoria being remote from any town, and they set out to provide a real link between the patients and the world outside, and to raise funds with which to provide amenities. The "Friends of Kelling" have in fact done more than this as their influence has spread to the surrounding area, bringing a new spirit into community life. Once each year a whole week is devoted to raising money, and a strong membership has done much for the sanatoria in three years. Amenities of many kinds, including a film-projector, have been provided and the children's sanatorium has been well stocked with toys. Billiards and sports competitions have been organised, entertainments have been provided, and there have been open-air religious services, garden parties and film-shows. All these activities have brought the outside world into the hospital and have given the patients constant friendship and interest, and zest for living. We were impressed to hear of the full co-operation not only of individual members of the organisation but also

of clubs and groups in the district which have produced evenings of entertainment, and helped with the running of competitions, parties and outings. It was clear that the "Friends of Kelling" had enlisted the full support of the community, of the medical and nursing staff of the sanatoria, and of the Management Committee and its staff. We feel that this is a particularly good example of what voluntary service can achieve with a community of purpose.

We believe that work with the chronic sick in hospitals is a rich field for voluntary service and a field which has so far only been partially explored. The voluntary societies are aware of this, and are ready to extend their activities. We hope that the staff of the chronic sick hospitals will welcome the voluntary worker, and that in a few years there will be established in them as strong a tradition of voluntary service as exists in the former voluntary hospitals.

Voluntary Work in Mental Hospitals

It is not always appreciated that in recent years there has been a marked change in the approach to mental illness, a change which has been reflected in the mental hospitals. Until comparatively recently mental illness was regarded as something quite apart from all other forms of illness, and the mental patient was entirely shut off from the outside world. The mental hospital, then commonly known as a "lunatic asylum," was essentially a place of detention. The Mental Treatment Act of 1930 embodied in legislation the new conception of mental disorder being a disease like other diseases which could in some cases be prevented and cured, and abolished the terms "lunatic" and "lunatic asylum." Nevertheless there are features in mental illness which make the mental hospital different in many respects from other hospitals.

Until recent years there has been no outside voluntary worker giving service in mental hospitals. Even now, although a start has been made, voluntary activity is found in only a few of these hospitals, and the scope of such activity is greatly restricted. It must be recognised that conditions in most of the mental hospitals are such as to make possible only some of the kinds of voluntary service that are given in other types of hospital. The voluntary worker cannot be allowed to associate with patients suffering from acute mental derangement, and some parts of the hospitals must therefore remain closed to voluntary service of any kind. Even with patients whose derangement is less serious normal human contacts are by no means easy for people who are not specially trained for the purpose, or accustomed to it. Furthermore, in most mental hospitals the wards are filled to their maximum capacity. Although over 40 per cent. of all hospital beds are allocated to mental patients there is still a serious shortage of accommodation.

Visiting by voluntary workers is being tried in some mental hospitals. We feel that it is too early to assess the value of this. Some medical superintendents speak well of it, and want to continue the experiment. The experience of the voluntary societies is as yet slight, but they are interested in the opportunity of exploring a new field of work. We have been told that the volunteer visitor may become the recipient of outpourings of hallucination, and that in consequence visitors have to be carefully selected. In some places patients who are well enough are taken by voluntary workers outside the hospital for outings or for tea in private homes. Some medical superintendents have spoken

highly of the value of this as contributing to the readjustment of such patients to normal living conditions before their discharge.

Shops are provided in a few mental hospitals by voluntary societies, and are staffed by voluntary workers. The trolley-shop does not seem to be suitable for most hospitals of this kind and it appears to be better for patients to visit the shop. Library services are provided also in some hospitals. There is a particularly interesting experiment in the Picture Library provided by the British Red Cross Society. Reproductions of good quality are sent to mental hospitals (and also to other hospitals with long-stay patients) and are changed after a short period. The organisers of the Picture Library have been encouraged by the interest shown by patients, and some medical superintendents have given the scheme strong support. A few mental hospitals are employing Occupational Therapists and Art Therapists, but there appears to be scope in this field for the voluntary worker with art and crafts training and with psychological training or at least a special sensitivity to maladjusted people.

Music also seems to have a contribution to make in the field of mental health. There are interesting musical activities in some hospitals, and valuable pioneer work is being done by the Council for Music in Hospitals which sends visiting artists to mental hospitals at a small charge to give short programmes to the patients. The effect of music on mental disorder is being carefully observed in some hospitals. The Council also stimulates local activity in the formation of music clubs and gramophone clubs in hospitals, and it appears to us that suitably trained voluntary workers might well follow up this work in individual hospitals. We heard of dramatic work being tried in one hospital, and the results are said to be encouraging.

We feel that in order to avoid giving a false impression we must again emphasise that voluntary service of these kinds is at present to be found in only a few mental hospitals. A start has been made, but no more than a start. The question arises whether more extensive voluntary activity is needed, or is practicable. In mental hospitals some of the activities and services which are provided in hospitals for the acute sick by voluntary societies are provided internally by the hospital staff and patients. Some patients are well able to organise activities for themselves, and are encouraged to do so. There is little need for such forms of service as washing-up, serving meals and orderly work in mental hospitals since many of the patients are able to help with these duties. We are indeed inclined to the view that the range of voluntary activity for the mental patient is not likely to be increased much beyond that existing in the hospitals where voluntary work has been developed to any extent. We are, however, concerned that such voluntary service as can be given successfully in mental hospitals should be given in all such hospitals. We think that some of the staffs of mental hospitals are not fully aware of what voluntary service can contribute to their work; equally we feel that voluntary societies should appreciate the limitations caused by the special nature of mental illness. Voluntary activity in mental hospitals is as yet new and experimental. The voluntary societies have so far made little progress; in some places they have felt that they have had no encouragement. We feel confident that there could be a steady expansion of activity within the practicable range of work, but we believe that the invitation should come from the mental hospitals.

We have come to realise that there are important tasks of a rather different kind which voluntary service can, and should, undertake in the field of mental health. We do not feel that the new conception of mental illness is as yet widely accepted, or even understood. The mental hospital is still an unknown world, and an alarming world, to the general public. We believe that there are ways in which voluntary service can help to educate people generally about mental health and sickness, and in this way to weaken the barrier between the mental hospital and the outside world. The voluntary worker who works in a mental hospital soon loses any fear of mental illness, and can convey this to the people outside the hospital. It appears to us important also that there should be close personal contact, as exists already in a few places, between the staff of mental hospitals and the people of the district. This should be of benefit not only to the people outside the hospital but also to the staff who live and work in a very abnormal environment and who must appreciate the chance of normal social life. Such contacts will gradually spread knowledge about modern forms of treatment and will dispel the fear which too often prevents people from seeking treatment in the early stages of mental illness. We believe that in this there is a field of work of great potential importance, and we encourage the voluntary societies to explore its possibilities. We are confident that the National Association for Mental Health, which is already undertaking this work of public education, will welcome support from other voluntary societies and from individuals who will offer their services.

We were particularly interested in the way in which the process of educating people in the new conception of mental illness is being undertaken at a London hospital for children with mental defect. Here the parents are closely associated with the hospital through a flourishing parents' association, run by a voluntary committee of parents, which organises outings for the children in a special motor-coach for which the association raised a substantial sum of money, and runs social activities for parents, the hospital staff and the children. We were told that this form of collective activity had greatly helped the parents to face the distress caused by their children's affliction, and had made them loyal supporters of the hospital. Parents' associations are to be found in some other children's hospitals.

A similar example of the education of public opinion was found at a mental hospital in the London area where there is a flourishing Patients' Visitors Association which plays an important part in the life of the hospital, and which in fact undertakes much that might otherwise be done by voluntary societies and local groups. We were interested to hear that some members continued to work actively for the association although they no longer had a relative in the hospital as a patient. This hospital has the advantage of receiving patients from the relatively compact area of one County Borough, and it seems to have made good use of its opportunities in the development of a close link, through the Patients' Visitors Association and in other ways, with the community that it serves.

We believe also that voluntary societies might make an important contribution in the field of mental health by providing homes and centres in which people suffering from milder kinds of mental illness and nervous disorders can be treated, and by helping with social and creative activities in them. There are experiments of this kind already in existence. Such homes and centres must, of course, be directed by qualified and experienced people, but excellent use could be made, under their guidance, of volunteer workers whose particular talents equip them for work in this field. Their contribution would have the special value of removing the atmosphere of segregation which is associ-

ated, not least in the minds of people in the early stages of mental disorder, with this type of illness. This is recognised as an important point in a social centre for ex-mental patients in a northern city where members of the Women's Voluntary Services share a club life with the patients, playing whist and other games with them, organising hair-dressing and similar services for the women, and running a canteen.

The field of mental health is, as has been shown, one in which development has been comparatively recent. The fact that there is as yet little voluntary service in it should not be taken as an indication that voluntary service has little to offer. The precise contribution that it can make will be shown in the light of experience and experiment.

General Conclusions

We have been much impressed by what we have seen and heard of voluntary service in hospitals. There is a wide range of activity varying according to the special needs of individual hospitals, and there is much evidence of initiative and imagination having been shown by the voluntary societies and local groups. Furthermore, we have seen that the voluntary societies are not standing still ; as new needs arise they are met.

We recognise, however, that voluntary service in hospitals presents problems, some of which are difficult to solve. Perhaps the greatest problem is that of obtaining enough suitable people to do the work. The recruitment and training of voluntary workers is of vital importance.

Another problem is that of space. In many hospitals space is limited ; some hospitals suffer from bad planning, and most are full to capacity owing to the general shortage of beds. In these conditions it is by no means easy to find room for such amenities as out-patient canteens and libraries. In some places, however, there has been remarkably effective improvisation which has shown that such difficulties can be overcome and can rarely, if ever, be used as a valid argument against the provision of amenities for patients, visitors, or staff.

Time presents further difficulties. Voluntary activities must take place only at certain times of day, and everything has to be fitted in to the normal routine of the hospital. In a large hospital the trolley-shop may have to be in the wards for over two hours if all patients are to be served, and it cannot be there when the medical staff are at work in the wards or when patients are being washed or are receiving treatment. It might well be mentioned that it takes some time also to prepare the trolley-shop for its rounds and to dismantle it afterwards. Library services present similar problems. Entertainments can only be given at certain times and must keep strictly to time : one break in hospital routine may affect the working of the entire hospital, and an entertainment which over-runs its allotted time may cause dislocation and additional work for the hospital staff.

Difficult though such problems are, they can be solved by goodwill and efficiency on the part of the voluntary workers and the hospital staff. We have come to realise that the most important contributory factor to the success of voluntary service in hospitals is that of personal relationships : indeed, where personal relationships are good no such problem is insoluble. We see voluntary service in hospitals as a partnership between the official hospital staff and the voluntary workers, based on a partnership between the hospital and the voluntary societies and groups. Partnership demands that each partner

accepts responsibilities. The voluntary societies and groups must accept the responsibility of undertaking the work that they offer efficiently and conscientiously, and the voluntary worker must reflect this in all his or her work in the hospital; the hospital must accept the responsibility of giving to the voluntary societies and groups the facilities which will enable them to fulfil their commitments, and the hospital staff must reflect this by knowing how to make the best use of what is offered. The use of the voluntary worker to the best advantage is a skill which can be acquired. It is perhaps not easy to see the need for acquiring this skill in hospitals where conditions are good, and where the need for voluntary service is not obvious. In our view the need exists however good the conditions may be, since we feel that in the partnership of the official staff with the voluntary staff there is a richness which is of immense benefit to the hospital. With this mixture we believe that a hospital cannot have a purely utilitarian function, but will always be an essentially human institution.

Voluntary workers in hospitals should be thoroughly familiar with hospital routine. If they are prepared to accept such limitations as it may impose on their work, with the realisation that the limitations are unavoidable, their work will be the more appreciated by the hospital staff. We believe in the importance of each partner understanding the position and problems of the other as a firm basis for co-operation; where such a relationship is established the voluntary worker is made to feel a member of the hospital staff, and will without question accept the hospital tradition of appreciating the strictly confidential nature of everything that takes place. Any breach of confidence would necessarily undermine this relationship.

We have found that a good many responsible members of hospital staffs know very little about the voluntary societies and groups which can help the hospital, and about the ways in which they can help. We feel that this is by no means the fault only of the hospital staff, who have all too little time in their busy working life for outside contacts, and that the voluntary societies and groups should do more than they do at present to advertise their wares. This is particularly important in places where there are former municipal hospitals which have not been used to having voluntary workers.

There is an old and well-worn criticism that the voluntary worker is unpunctual and unreliable. A hospital has to work to time and work cannot easily be postponed from day to day. If these criticisms are justified, and are of general application, there can be no place in the hospital for the voluntary worker. In fact many thousands of voluntary workers are giving their services to the hospitals with considerable success, and are proving the old criticism to be untrue.

We have heard it said that, while the enthusiastic keenness of the voluntary worker who is undertaking pioneer work is a joy to behold, such enthusiasm does not stand the test of time, and that those who continue an established activity when the pioneers have left it tend to find it dull and unrewarding, and so become unreliable. Even the best voluntary society has to recognise that its members have human failings, and we must admit that to carry on a routine job week after week with never-failing industry and efficiency is a stern test of character. From what we have seen of voluntary activity in the hospitals we have been impressed by the high quality of the service that appears to be maintained from day to day and from week to week, and we have come to the conclusion that the great majority of those who give personal service in the hospitals have a high sense of vocation which remains a living inspiration for their work.

(ii) Voluntary Service outside the Hospital

There is a rich field of voluntary service outside the hospital, but connected with the hospital. Hospitals should never be isolated units having no relation with life outside their walls. Patients come and go, and the time spent in hospital is but a part of the experience of illness. Illness causes all kinds of problems to arise, and many of these cannot be solved without help. There are in fact a great number of services made available to the patient who needs them by the Local Authorities, and by voluntary societies and local groups, and we have been impressed by the extent and variety of these services.

It is important that there should be a clearly defined link between the professional organisation of the hospital and the Local Authorities and voluntary societies which offer services to the patient, and it seems to us that the link between the hospital and the district which it serves should normally be the almoner, and, in the mental hospital, the social worker. The almoner is a professional medical-social worker on the hospital staff. The profession of hospital almoner started just over fifty years ago when a trained social worker was appointed to the staff of the Royal Free Hospital. Before 1948, although a few Local Authorities had appointed almoners to work in the municipal hospitals, they were to be found almost exclusively in the voluntary hospitals, and one of their functions, which took an undue proportion of their time, was the assessment of financial contributions by patients according to their ability to pay. This was, however, never regarded by almoners as their principal function, and, when in 1948 hospital treatment became free, they were able to devote the greater part of their time to their more important work of helping through social work in the cure and, where necessary, the rehabilitation of individual patients.

It is now generally recognised by the medical profession that the condition of a patient in hospital may be seriously affected by personal problems and social difficulties, and that such external influences may retard recovery. It is part of an almoner's work to investigate the social background in such cases, and to report to the doctors. It is also her function to endeavour to solve the patients' problems and remove the difficulties which cause anxiety. Almoners recognise that for much of their work, both in investigating problems and in finding solutions, they need outside help, and they therefore work closely with the officers of Local Authorities who are engaged on social case-work, and with the voluntary societies.

The number of almoners and social workers available is not nearly large enough to meet the needs of the hospitals. Many hospitals, particularly the former municipal hospitals, have no almoner, and in many hospitals which have almoners the number is inadequate to deal with the amount of work to be done. Some almoners try to see every patient admitted to the hospital and assess for themselves whether background information is needed or help is required. Others work more intensively with a smaller number of patients referred to them by the medical or nursing staff. Whichever method is adopted, the amount of work involved is considerable, and almoners find it necessary to make use of all possible outside help. It is clearly right that the voluntary societies should give the almoners all the help that they can, and take their share in this valuable social work.

This places a great responsibility on the voluntary societies. Social case-work is not easy, and is not work for an untrained amateur. If the voluntary society is to give the help that is needed its workers must be trained to be proficient. Almoners will rightly

require a high standard of work, and the voluntary societies will fail if they offer less than this.

Almoners have to obtain a great deal of information of a private and personal nature, and it is a tradition of the profession that all such information is treated in strict confidence. It is of the utmost importance that voluntary workers who undertake investigations for almoners, or help them to deal with personal problems which have come to their notice, should fully respect their secrecy. Only where this is done can mutual confidence be based on sure foundations.

It is important that there should be free exchange of information between the almoners and the voluntary societies with which they work. The almoner should, in our view, keep in close personal touch with the voluntary societies, and be ready to discuss her work with them. The voluntary societies should keep the almoner fully informed about their activities, and the kinds and amount of help that they can offer, and should endeavour to provide between them a full range of services so that the needs of patients can always be met.

In our investigations we have seen something of these needs, and something of the ways in which voluntary workers are helping to meet them. The picture that we give is certainly incomplete, but we believe that it covers the main activities of the voluntary societies and local groups, and gives a general idea of the ways in which voluntary service is working in conjunction with the hospital service.

Services in the Home

So far as the hospital service is concerned, voluntary service in the home may be said to fall into three categories—the care of the patient before going to hospital; dealing with difficulties which arise in the home as a result of the patient being in hospital; and the care of the patient in the home after discharge from hospital. The care of the aged and infirm in the home is a special problem which will be dealt with later in this report.

Voluntary service in people's homes is by no means easy, and demands tact and sympathetic understanding. The aim of voluntary service is to help in time of need, not to interfere with private life, and the successful voluntary worker will be looked on as a friend in need and not a busybody. At the same time she should see that advantage is not taken of her willingness to help—as one social worker has said to us, "it is a mistake to do too much." Unfortunately there are some people who take advantage of the generosity of others, and the voluntary worker should remember that one object of this kind of service is to help people to help themselves.

Illness inevitably causes dislocation and difficulties in the home, and help is not always easy to find. We feel that the voluntary societies would make a valuable contribution if they set out to make known throughout the districts which they serve what services are available and how they can be obtained when the need arises.

Under the National Health Service Act, 1946, the Local Health Authorities are given the duty of providing health visitors "for the purpose of giving advice as to the care of young children, persons suffering from illness, and expectant or nursing mothers, and as to measures necessary to prevent the spread of infection," and also of "securing the attendance of nurses on persons who require nursing in their own homes." In each case they may provide the service through the agency of voluntary societies. They are also given the power, but not the duty, of making arrangements for providing "domestic help for households where such help is required owing to the presence of any person who is ill, lying-in, an expectant mother, mentally defective, aged, or a child not over compulsory

school age." Health visitors have been employed by Local Authorities for many years ; home nursing has now become a statutory responsibility of Local Authorities run for them by a voluntary society, the Queen's Institute of District Nursing, which has provided the service for many years from its own resources with grant aid ; the home-help service is a new service. In some places the Local Authority provides and runs a home-help service ; in other places the Local Authority arranges for the service to be provided by voluntary societies on a repayment basis ; in places where there is no official scheme, or where there are not enough home-helps employed, voluntary societies endeavour to meet the need from their own resources.

Where a home-help is provided under an official scheme the Local Authority is given power to make a charge according to the ability of the householder to pay. Women are employed for the service and work a set number of hours. The rate of pay is often lower than the normal rate for part-time domestic workers, and there is evidence that many women undertake the work with a sense of vocation and do more than they are paid to do. Their normal duties cover housework, laundering, cooking and shopping, but we have learned that many give extra help outside their hours of duty when they feel that help is needed.

Where voluntary service is provided to supplement the official service, a position of some difficulty tends to arise. Some women who will readily give their services to a voluntary society feel a sense of injustice if they are called upon to do work for which others are being paid. There appears to be no simple answer to this problem, which is liable to arise in any service in which there are both paid workers and voluntary workers.

In some places voluntary societies are providing additional services to help when there is illness in the home. For instance, the Women's Voluntary Services in one region organise a service of "sitters-up" who stay in the house all night and attend to the needs of the patient. An appeal was made in the press and resulted in fifty volunteers sending in their names. "Sitters-up" are paid ten shillings a night, and are provided by the householder with refreshments. When the householder cannot afford to pay, he may, if he is receiving help from the Assistance Board, apply for an increased grant for this purpose. Similar services are operated elsewhere by other voluntary societies.

The difficulties which arise in a home where a housewife has to go to hospital are too many and varied to be mentioned. In some cases relations and friends can give their help, but in other cases outside help is essential. Most voluntary societies help in cases of this kind when they are brought to their notice ; often the almoner will hear of the difficulties from the patient and will get in touch with the voluntary societies. It seems to us that more voluntary societies would do well to run a service of emergency helpers who could be sent at short notice to do anything that was needed.

When a patient is ready for discharge from hospital there are several services which can be made available by voluntary societies. In some cases the time of discharge may depend on the suitability of the home conditions to the patient's state of health, and the almoner may seek for information to give to the doctors. Voluntary societies will arrange for the home to be visited and a report to be made to the almoner. There can be extensions of this ; for instance, in at least one of their regions the Women's Voluntary Services run a "home-coming" service, and voluntary workers not only investigate the home conditions but also prepare the home for the patient's return and help the patient to settle in. When this service was started it was anticipated that the greatest demand for it would come from women living in isolated country homes ; in fact, so we were

informed, there has been an even greater demand from men living in the towns. Similar services are provided by other voluntary societies.

Some patients discharged from hospital need to use special medical appliances and equipment. Since these tend to be expensive, and normally would be used for only a short time, St. John Ambulance Brigade and the British Red Cross Society maintain medical loan stores from which, on application, they can be obtained on free loan. We understand that this service is used extensively. These voluntary societies, and others, also provide special foods required by invalids, either free or at a small charge. The British Red Cross Society has a special service for dealing with emergency supplies for patients who are dangerously ill. Clothing and linen are also supplied in cases of special need.

St. John Ambulance Brigade and the British Red Cross Society operate an emergency help service for ex-service men and women through which they aim to meet all needs which arise. Other special services are supplied to cripples by the larger voluntary societies and by societies which are specially devoted to the care of cripples. Special apparatus, such as wheel-chairs, is supplied, and all possible help is given to enable the cripple to lead a less isolated and helpless life. Instruction of various kinds is given in the home ; for instance, in a large northern city the Cripples Help Society employs nine occupational therapists for work of this kind.

Physiotherapy outside the hospitals is in many places provided by voluntary societies, particularly by St. John Ambulance Brigade and the British Red Cross Society. Physiotherapy clinics are established at appropriate centres, and in some areas, particularly in rural areas, mobile physiotherapy units have been provided so that the service can be extended to those who cannot leave their homes. The clinics and mobile units are staffed by trained physiotherapists and voluntary helpers, and treatment is given on a doctor's request. In some places the service is provided by various societies and groups acting jointly. The vans with their equipment are provided with money from voluntary funds which have been obtained from individual subscribers and from many different sources. Contributions from patients who can afford to pay for their treatment help to meet the costs of maintenance.

It is our impression that the voluntary societies and local groups can provide most services that are required in the home, and will provide them when they are called on to do so. We are not sure, however, that there is yet adequate machinery for bringing cases of need to their attention. We feel that all possible means of publicity should be used, so that everyone may come to know what help is available and how it can be obtained. No doubt the voluntary societies in each place or district will be able to ensure that there is some "clearing-house" machinery so that services may not be unnecessarily duplicated, and that all needs can be met. Some measure of co-ordination appears to be necessary for this purpose, and in some places appropriate co-ordinating committees exist. This seems to us to be the particular contribution that Councils of Social Service in the towns, and Rural Community Councils in country districts, are by experience best qualified to make. We have no wish to see standardised voluntary services, and we do not suggest co-ordination for this purpose ; we are merely concerned to ensure that the available resources are put to the best possible use, and that between them the voluntary societies and local groups can provide all the forms of voluntary service that are required to meet the diversity of needs which arise.

Services in Convalescence

In the latter part of the 19th century a large number of convalescent homes were provided by voluntary endeavour, and by the end of the century convalescence in a home after treatment was not unusual. In the first half of the present century many more homes were provided, but, as in the case of the hospitals, there was no co-ordination of individual enterprise. Before the National Health Service Act came into operation all but a very few convalescent homes were under voluntary management.

The National Health Service Act of 1946 provided for the transfer to the Minister of Health of institutions "for the reception and treatment of persons during convalescence," gave to the Regional Hospital Boards the duty of providing for patients who required convalescent treatment, and gave to the Local Health Authorities the power to provide for patients who required convalescence which did not involve treatment. In fact the great majority of homes were not transferred, being disclaimed under Section 6 (3) of the Act, and it was indicated by the Ministry in circulars that in general they were accepting the transfer of homes which gave treatment, and were disclaiming homes which did not. The latter were defined as homes which provided for patients who required "little or no more than rest, good food, fresh air and regular hours," and it was stated that, while "treatment" was not easy to define, the former would be homes providing more than these and certainly providing "regular medical supervision and nursing care."

To-day there are therefore some convalescent homes which are owned by the State and administered by the Regional Hospital Boards and Management Committees, and a great many voluntary homes some of which take patients for the Regional Boards and Local Health Authorities, and some of which take private patients only. There are other convalescent homes restricted by their Trust Deeds to special kinds of patients, and others which are run for private profit. The position is made more confusing by the financial arrangements. Patients sent to convalescent homes by the Regional Hospital Boards receive treatment and board free of charge, while patients sent by Local Health Authorities are required to pay part of the cost according to their means ; moreover the assessments differ from one Local Health Authority to another. There are convalescent homes which take patients both from the Regional Hospital Boards and the Local Health Authorities : some patients therefore pay nothing, and others in the same home have to pay something, the amounts varying according to where they come from. Private homes charge their normal fees, but patients who are members of contributory schemes can receive financial benefits in payment or part-payment of these fees.

The voluntary homes have been provided by a great many voluntary societies and local groups and trusts. The larger societies have some, but not many, convalescent homes. The Churches and the Jewish Board of Guardians, trade associations and industrial firms, the Friendly Societies, and Contributory Schemes provide and maintain a fair number of homes, and homes for children are provided by such societies as the Invalid Children's Aid Association and the Shaftesbury Society, but, in the main, convalescent homes have been provided by individual benefaction or by local initiative. It is a field in which there have been opportunities for voluntary endeavour, and much has been done.

There is, however, much more to be done. In the first place there are many examples of quite serious delay in the admission of patients to convalescent homes : a recent survey of the position in the London area showed that 28 per cent. of in-patients in 19 hospitals had to wait an average of 8 days in hospital after being fit for transfer to a home. This suggests that there are not enough convalescent homes, but, while this is true of certain

parts of the country, it is not the whole picture. The pressure on convalescent home accommodation is very heavy during the summer months, but in the winter there are many homes with unoccupied beds. There appears to be a need to provide more homes in areas which are badly served, and to ensure a more even flow of patients to the homes throughout the year. The South of England is reasonably well served, although there are waiting-lists, particularly for children and old people. The North is much less well served; convalescent homes having been developed by individual initiative were normally situated in places with a specially suitable climate, and thus mainly in the south, without regard to the need for ensuring that all parts of the country had convalescent homes within easy reach. The provision of new homes is very costly, and normally beyond the reach of the voluntary societies, especially now that financial help is more difficult than ever to get. New convalescent homes and recuperative homes may have to be provided mainly by the Regional Hospital Boards and the Local Health Authorities.

The Contributory Schemes own and run a number of convalescent homes providing in all about 1,000 beds, and, since they are generally in a good financial position, they can afford to maintain high standards, but the voluntary societies are in a different position and it would appear that, unless some way can be found by which they can continue to run their homes with running costs at their present high level, the responsibilities of the public authorities will be increased. The societies feel that they cannot increase their fees beyond certain limits without reducing the number of admissions. Few private patients can afford to pay high fees, and the Regional Hospital Boards and Local Health Authorities are working on restricted budgets. King Edward's Hospital Fund for London in the period 1947 to 1950 made grants of £230,000 to homes serving the London area, mainly for capital projects, and thus helped to improve their standards of service, but this has not solved the problem of meeting maintenance costs, and it must be accepted that the financial burden of running convalescent homes, even with *per capita* payments from the public authorities, is more than most voluntary societies can bear.

If the State, acting through the Regional Hospital Boards and the Local Health Authorities, progressively provides and maintains more and more convalescent homes and recuperative homes, it is to be hoped that full advantage will be taken of the great wealth of experience of voluntary societies of many kinds and contributory schemes in the running of such homes; indeed, the voluntary societies and contributory schemes have almost the sole experience in this field of work, and the knowledge of method and practical detail which they have acquired over many years is of the greatest value. We feel that there is much to be said for leaving the management and administration of convalescent homes to the societies which have provided them, enabling them to meet the heavy costs of running the homes by grants from public funds on a basis which would relieve their financial anxieties. Furthermore, we believe that when new homes are provided from public funds the Regional Hospital Boards and Local Health Authorities would do well to entrust their management on an agency basis to those voluntary societies and contributory schemes which have shown their competence in this field of work.

Transport

The transport of patients and their relatives and friends to and from hospitals has for a long time been a concern of voluntary service. The transport of patients by ambulance requires skill and experience, and this service has been a special feature of the work of

St. John Ambulance Brigade and the British Red Cross Society who have trained men and women for this work. The transport of patients for whom travel by ambulance is not necessary, and of relatives and friends who live at some distance from hospitals, has been undertaken by a number of voluntary societies.

Under the National Health Service Act of 1946, the Local Health Authorities were given the duty of "securing that ambulances and other means of transport are available, where necessary, for the conveyance of persons suffering from illness or mental defectiveness or expectant or nursing mothers from places in their area to places in or outside their area," and of either providing the transport and necessary staff themselves, or of making arrangements for their provision by voluntary organisations.

The ambulance service operated in the past by St. John Ambulance Brigade and the British Red Cross Society established by years of loyal service to the public a unique place of trust. The ambulances were provided by charitable gifts from individuals, groups, societies and companies of every kind and the service was manned by a volunteer staff devoted to their work. With a national hospital service coming into being it was logical that the ambulance service should become a national responsibility through the Local Health Authorities. In fact in certain places the Authorities have chosen to make use of the voluntary societies in the fulfilment of their duties, and many ambulances are still manned by St. John and Red Cross workers, but in such cases the ambulance staffs are paid for their work. This, so we have been informed, has caused some distress, since the voluntary tradition dies hard. It may be that more than one place has the arrangement of which we heard in a small north-country town where the ambulance is manned on week-days by the paid staff and on Sundays by volunteers ; it was interesting to find that the volunteers consisted of the members of the paid staff together with women from the women's nursing division. From what we have seen we have formed the impression that the high standards of work and the spirit of service which activated the voluntary ambulance units in the past have been inherited by the national service now in operation.

The ambulance service is rightly available only for patients who need special care and skilled handling, but there are other patients who can travel in ordinary forms of transport. These include not only in-patients whose condition is such as to make the use of an ambulance unnecessary, but also out-patients who have long distances to travel to reach the hospital. Public transport is not always suitable or convenient, and much use is made of private cars driven by volunteer drivers. The hospital car service was started during the war, and was operated by the British Red Cross Society and the Women's Voluntary Services. Travelling in war-time was particularly difficult, and this made a valuable contribution ; among other benefits was the saving of man-hours in industry. Volunteers placed their private cars with drivers, usually themselves, at the disposal of the service, and many thousands of miles were recorded in the log-books of local units in both town and country districts. The service was found to be so useful that it has continued, although in a modified form, and, as an example, it was of interest to us to learn that in a southern county the hospital car service conveyed 1,500 to 1,800 patients a month and covered an average of 15,000 to 18,000 miles a month ; and that in East Anglia, which is typical of a scattered rural area, the car service had in a period of six months undertaken 11,000 journeys conveying 13,000 patients for a distance of 323,000 miles. A mileage allowance of 7d. a mile may be claimed by the car owner.

No provision is made in the National Health Service Act for the transport of relatives and friends of patients in hospital, but the voluntary hospital car service may be used, when circumstances justify it, for this purpose. A farmer's wife cannot easily leave the farm for a whole day, especially if her husband is in hospital, but a visit to the hospital by car may well take her away for only a few hours. We were told of one case in which the hospital car service had made it possible for a young chronic sick patient to be visited by her sister, her only living relative, whom she had not seen for over a year; the sister lived on an isolated farm in the adjoining county and a journey by public transport would have made it necessary for her to spend a night away from home, which could not be managed. In one northern city the Hospitals Council, which operates the contributory schemes, runs a night volunteer car service to bring relatives to hospitals when urgent need arises; the service has recruited two-hundred volunteers who will turn out when asked to do so, and who pay for the petrol used.

The hospital car service is also used to take patients from hospitals to convalescent homes and recuperative homes, or to their own homes, when they are discharged from hospital. Since the war travelling conditions have much improved, but even so a journey by public transport is an ordeal for a newly-discharged patient, and the use of the "door-to-door" hospital car service is clearly justified in many cases.

A particular feature of the hospital car service is its kindly unobtrusiveness. An ambulance at the door provides a sensational interest to the neighbours which may cause an embarrassment to the patient. Its stretchers and general appearance may well add to the fear of going to hospital. A private car excites little or no attention and, with a sympathetic person as driver, the journey to hospital will lose its frightening abnormality.

Any such service is open to abuses and the hospital car service has been no exception. It has often been said that while petrol was rationed there were people who offered the use of their cars in order to get petrol. We have been told that hospital cars have been used to take parties from the country to the town for their shopping on a flimsy excuse of attendance at an out-patient clinic, and we have heard that even ambulances have been used for unnecessary journeys. We have, however, been assured by those who have experience of organising the car service that all such abuses can be prevented through the co-operation of the doctors: if the doctors ensure that ambulances and hospital cars are ordered only for patients who really need them, making careful enquiries if necessary, irresponsibility of this kind is defeated.

We have been much impressed by what we have seen and heard of this service. We believe that it meets a real need, a need which will continue to exist, and that it is admirably organised by the St. John Ambulance Brigade, the British Red Cross Society and the Women's Voluntary Services. We feel that the voluntary element in this service introduces valuable features which could not be reproduced in an extension of official hospital transport.

Old People's Welfare

In our report on voluntary activity in hospitals for the chronic sick we have shown that in these hospitals there are a number of old people who are infirm rather than ill, and who could in certain conditions be cared for adequately outside the hospital. We have also indicated that it is the general policy of geriatrists to keep old people out of hospital as long as possible, and to discharge from hospital those who become fit enough

to lead a normal life. It is generally known that there is a serious shortage of hospital beds for people who need treatment, and it would clearly be of benefit to the hospital service, and to many old people, if the number of patients in chronic-sick hospitals could be substantially reduced. This can only be possible if the old people can be properly cared for outside the hospital. We have therefore considered it necessary to survey briefly the work which is being done in Old People's Welfare, voluntary work that is making a contribution to the hospital service which, if indirect, is of immense value.

The range of work in the field of old people's welfare is potentially enormous. Several factors contribute to this. The advance of medical knowledge and the improvement of medical techniques have greatly increased the number of old people living, and, with the fall of the birth-rate between the two wars, the proportion of old people to young is greater than ever before. At the same time it has become increasingly difficult to look after old people individually. The modern small house, which has been the unit of housing development, is planned for the small family and provides little space for looking after aged relations, and, with a high level of employment absorbing not only men but often their wives as well, there are fewer people than there were to look after them at home. Rising wages have been followed by rising prices, and, since the high cost of living does not make it easy to provide for an extra member of the family who can bring in no more than an old-age pension, it is easier and cheaper for the family if their aged relatives can be placed in a hospital or an old people's home. It is hardly surprising that once old people are in a hospital or a home it is very difficult to get them out. It should perhaps be mentioned, as an additional factor, that there appears to have been a decline in the sense of responsibility of many people towards their ageing relatives.

It must be accepted that old people are generally not easy to look after. They often demand a great amount of care and attention ; alternatively their determined independence is a source of anxiety to those responsibile for them, perverse and ill-timed as it may be. If they are merely ailing and infirm they do not need skilled nursing care, and a harmless senility does not require the skilled attention needed for senile dementia. In a great number of cases there is nothing that is beyond the range of family home nursing, although, since a minor affliction may suddenly develop into a serious illness, those who care for old people must always be prepared for an emergency. There can be no doubt that in very many families an old person is a problem, but it is a serious step to find a solution that results in a denial of home life in old age, and we believe that the solution should be sought within the family before it is sought elsewhere. A society that is based on the family will lose something vital if it removes from its members all responsibility for the individual care of those who grow old.

Earlier in this report we have shown how by a combination of the work of the professional hospital staff and the work of voluntary societies old people who are in hospital can lead happy and purposeful lives. We feel that the work of the voluntary societies, together with that of the professional Health Visitors and Welfare Officers of the Local Authorities, can do much to achieve the same aim for those who are outside hospital and who can still lead something of a normal life.

Service for old people outside hospitals seems to fall broadly into three categories. There is service which is designed to increase their material and physical comfort, service which aims at providing entertainment and interest and thus alleviating loneliness, and service which relieves them of work and aids them in infirmity. A very large number of

voluntary societies and local groups are undertaking one or more forms of service for old people, and it is perhaps natural that in our investigations we should find some apprehension lest there should be overlapping of service given by the various organisations and individuals. We are inclined to believe that there is a clear need for co-ordination of effort in this field of work. There can be few, if any, old people who are helped too much; there must be many who are helped too little. The amount of service at present available cannot meet all needs, and it seems to us important that it should be spread as widely as possible so that, if possible, everyone who needs help shall have some help, even if it is only a little. Co-ordination of this kind is not easy, and we commend the valuable work that is done by the National Old People's Welfare Committee and by its constituent Old People's Welfare Committees throughout the country.

Some of the services given to old people have become well-known, as, for instance, the "meals on wheels" service. One organisation may take sole responsibility for this service, or several groups may combine to provide it jointly, but generally speaking the routine is the same everywhere. The voluntary workers collect the food from a central kitchen in containers and distribute hot meals to old people in their homes. In many places the service is run in conjunction with the Local Authority and the meals are cooked in a Civic Restaurant. Where this cannot be arranged volunteers have sometimes succeeded in devising ingenious and competent improvisation and have produced and staffed a central kitchen themselves. We have heard in many places of the readiness of people to give their services for this work. In one city an advertisement in the press for volunteers to relieve the regular team at holiday periods brought over fifty replies, one from a bus-driver who has since joined the regular team on his day off each week. This service demands high standards and is a test of the loyalty and devotion of voluntary workers to their job. The vans must go out each day and in all weathers, and this requires consistent and unsparing effort and efficient administration. We have been much impressed by the high standards achieved, and we have observed that the service does more than provide meals: it provides regular and friendly visitors who are welcomed. The van staffs can also help unobtrusively in another way; on their visits they can see whether other forms of help seem to be needed. Old people have told us that it gives them the feeling that someone is looking after them, and that this is a service that never fails.

Many old people lead a lonely existence and welcome the chance of social life. In many places voluntary societies and local groups provide "Darby and Joan "clubs where they can meet each week and have a good time, and, by so doing, feel a sense of still being a part of a community. The clubs normally meet in the afternoon, on one or two days each week, and include in their programme games and gossip, refreshments, singing and sometimes dancing. If songs and dances belong to the Edwardian period they are all the more popular. Birthdays of members and Christmas are celebrated with special treats, and there are summer outings and, sometimes, even summer holidays. Behind all these arrangements there must be a skilful administration supported by voluntary workers with a generous variety of talents. All kinds of societies, groups and organisations help with these clubs and with services connected with them, such as bringing infirm members to the club by car, or collecting savings to help towards the cost of outings. It is often very difficult to find suitable premises. Church halls and public halls are much in demand as being, normally, the only rooms large enough for the purpose that are available in the afternoon. One "Darby and Joan" club in London takes great pride in its

premises which are used later for a night-club, and which are made available at a very small charge by a generous proprietor. The old people in this club are enchanted by the luxurious furnishing and equipment which add spice to their entertainment.

We were interested to find an admirable service for old people's welfare in Bristol organised by an Old People's Welfare Committee under the sponsorship of the Council of Social Service. A wide range of services is provided, including a laundry service and a visiting chiropodist, for both of which a small charge is made that is willingly paid. If these services are provided elsewhere so much the better, for their benefit is considerable and they are greatly appreciated. Here, too, there seemed to us to be most successful co-operation between the voluntary committee and the Local Authority.

Many voluntary societies and local groups provide visitors for old people in their homes. It is not always easy work and visitors have to be carefully chosen. They must be tactful and understanding, and also shrewd. They must look for the genuine need and real hardship, and know them when they see them. The world for most old people gets smaller, and the visitor must appreciate how in both pleasure and grievance the smallest detail is magnified out of proportion. Many voluntary societies have great experience in this field of work and are skilled in the selection of visitors. They realise that old people welcome not only those who are nearing their age and have interests in common with them, but also like to see young life. We were particularly interested to learn of one association which has among its visitors to old people a number of young women who make their visits when they leave their work in shops and offices and have a cup of tea with their older friends ; we feel sure that this is not an isolated example.

Old people often want advice, about such matters as pensions or rent, or indeed, as one voluntary visitor said, "about nothing at all." Many have said how much they miss the Relieving Officer who used to help them in this way. Organisations meet this need by sending voluntary visitors who can answer their questions. From such talks it is often possible to discover genuine needs, and a visit may well lead to a gift of clothing from one of the clothing stores run by voluntary societies (to which further reference will be made), a wireless set for the bed-ridden, or a luminous stick for one whose sight has failed. Much can be done to help those who, while not actually ill, are near the borderline between health and sickness. Important as such service is, it is to most old people less important than friendship. They want to feel secure in their friends. They dread loneliness and the feeling of being unwanted. They appreciate understanding sympathy, but often they need the spur of usefulness to keep them up and about ; many need interesting contacts with the world outside their own small room if they are to remain alive until they die.

Books are still a pleasure and an interest for many old people, and a mobile library service, which many voluntary societies and groups arrange, can provide them ; this brings another visitor, the librarian, into the home. Instruction in simple crafts is often welcomed too. In some cases instruction is unnecessary but craft tools and materials are greatly needed ; one can appreciate how much it would mean to a craftsman who has used his skill all his life to be given a chance to use again the tools and materials with which he was so familiar. A voluntary society which provides these things, and arranges for the sale of what is made, is undertaking a most beneficial service.

There are many old people with no relatives to care for them who in their latter years are feeling the strain of a financial stringency which has hit most hardly the people with fixed incomes and with pensions. The shortage and the high cost of domestic labour

have produced heavy burdens for many old people who in a more leisurely age of economic security would have been able to look after themselves with such material comfort and help as they had been accustomed to have in the past. Such people often adopt a strongly independent attitude ; they are most reluctant to ask for help, which they regard as "charity," and are equally reluctant to make their difficulties known to other people. Those who are ailing and infirm present a serious problem ; even those who are well are a source of anxiety, since they may become invalids at any time and without anyone knowing what has befallen them. It seems to us that these people present a special field of work for voluntary service. Some societies, such as the Friends of the Poor, are undertaking admirable work among such people but there is much that still remains to be done.

So far we have been concerned with old people who are living independent lives in their own homes or with their relatives. It must, however, be recognised that there are many old people who can lead happier lives in homes with others of their own age and kind, and it has been widely recognized that there is an urgent need for more residential homes. A good many homes of this kind have already been provided by voluntary bodies, and there have been interesting experiments in planning ; in one midland city, for instance, which has a very active Council for Old People, care has been taken to provide homes so situated that old people can continue to live in the district in which they lived before. King Edward's Hospital Fund for London has allocated a very large sum from its funds for the provision of old people's homes, and has already opened the first two of a number of homes which it intends to provide in the London area as a "pilot" scheme. The National Corporation for the Care of Old People has allocated substantial funds obtained from the Nuffield Foundation, with which it is associated, to assist voluntary societies to provide homes, and further funds from the Lord Mayor's Air-Raid Distress Fund to make provision for homes in badly-bombed areas. Even so only a start has been made, and the task of providing the homes that are needed throughout the country is formidable. It is difficult to believe that all the homes that are needed can be provided from voluntary funds ; it is equally difficult to believe that voluntary funds can meet the immensely heavy costs of maintenance that will steadily increase as more homes are provided.

Whatever the future may be, it is appropriate that the work of pioneering in the provision of residential homes for old people should be undertaken by voluntary endeavour. The voluntary societies which have for some years provided homes for old people have a wealth of experience in practical points of detail, of building and furnishing, of staffing and administration. They know what is the best size of home, both for economical administration and for the satisfaction of those who live there. They know the kind of life, varying according to social background, which the old people will want to lead. Points of detail are important ; for instance, many old people will want to lead a life of their own, shopping and entertaining their friends in their own rooms, and yet will appreciate some measure of community life. Two homes which we saw require those who live there to have one meal a day all together, and take the opportunity to ensure that they have a good meal, but also allow them to prepare, and have, other meals in their rooms if they wish to do so. Naturally they have also to be prepared for increasing infirmity, and for sudden illness which may make necessary the transfer of an old person to hospital. Administration must always be flexible, and therefore careful planning is essential. Everything will depend on the person in charge, and the selection

and training of such people is vitally important. It requires special gifts to create a home in which old people can live happily with reasonable independence, can be cared for when they are sick and infirm, and can die in peace.

There is another type of home for old people that seems to be needed. Where old people are living with their families it is of great benefit to the family, and particularly to the housewife, who may be a daughter or daughter-in-law, if they can from time to time have a rest from their responsibilities. A fortnight's, or even a month's, relief from the daily task of fetching and carrying, watching and caring for an old person, may well add greatly to the happiness of the household. It would be a great contribution if there were "short-stay" homes for old people in which rooms could be reserved ahead. Help in other ways can often be given with advantage. Voluntary societies are naturally primarily engaged with the problem of the welfare of old people who cannot be cared for by their families, but they would do well to remember that some old people are living with their families in conditions that are far from ideal. Voluntary helpers—"sitters-up" and "sitters-in," friendly visitors, the library service, and others —are as welcome in these circumstances as in others, provided that they will accommodate themselves as necessary to family convenience. A helping-hand may often be a great relief.

A very considerable amount of work is needed in the field of old people's welfare. It is indeed a gigantic task and, although there are a number of voluntary societies entirely devoted to it, they are the first to say that so far only the fringe of the work has been touched. No one society will, of course, attempt to tackle the problem as a whole. It has many facets, and each society is so deeply concerned and so hard pressed in its particular field of work that it may have no time or opportunity to give thought to related problems, or to the work that others are doing in the same field. It is because of this that we feel that co-ordination of the work is of special value. The individual experience of the various societies and local groups needs to be pooled so that each may learn from the others. We feel too that in many practical ways the societies and local groups can get help from each other, but only if they know where to go for help.

Finally we wish to re-emphasise our view that a solution to the problem of caring for old people should be sought first within the family, and that only if that fails should it be sought outside. We believe that one of the tasks of the voluntary societies may be to educate people to see their family responsibilities. In a society which provides much in the way of welfare for all its citizens it is perhaps natural that the awareness of personal responsibilities should weaken, yet a free society demands that its members should accept responsibilities. The family is the group on which society rests, and a sense of responsibility of all members of the family for each other, willingly taken, should surely be a basic foundation of family life—although we do not feel that a family is justified in fulfilling its responsibilities by the sacrifice of one of its members on whom the whole of the burden falls, often a person who could otherwise lead a more useful life. Since the care of old people in the home demands the use of techniques and skills we feel that there is great need for home-care and home-nursing to be revived and encouraged. To try to get an old person into a hospital or home should be the last resort instead of the first. Everywhere among people who are working for the welfare of old people have we found a great anxiety that this should be so, and we feel that it is perhaps the peculiar and happy prerogative of voluntary societies to take the lead in this important task of social education.

After-Care

Most people on leaving hospital need special care and attention, if only for a short time. Some are sent to convalescent homes or recuperative homes, and others can be well looked after in their own homes, but there are many people who have to return to conditions which are unsuitable for their state of health. For these the "after-care" services provided by Local Authorities, and by many voluntary societies and local groups, can be of immense benefit. The same conditions as make the care of old people at home a real problem intensify the difficulties of convalescence. Not only is help not generally available, but the comforts which can lighten convalescence are often more expensive than most people can afford. Ordinary living in these conditions becomes a struggle for anyone who has recently been seriously ill, and a helping hand is needed.

We have already reported on services which are available in the home, and have shown that much help is given by the Local Authorities and voluntary societies, but it is impossible to judge whether the needs are in fact being met in full, since we have no means of finding out whether there are many, or few, convalescents who need more than they receive. It is important to remember that no one is compelled to receive after-care, that information about people's needs often reaches Local Authorities and voluntary societies almost by chance, and that there are people who choose to keep their troubles to themselves. It is our general impression that there is an increasing demand for the services that are available as more and more people hear about them and hear from others how much help they give in time of need. Even so, as we stated earlier, we feel that there should be more publicity, so that everyone may come to know what help is available and how it can be obtained.

Health visitors, district nurses, home-helps, hospital almoners and the workers of voluntary societies all play their part in individual cases. In the provision of after-care there is no set pattern of procedure. The danger of this is not that there is likely to be overlapping, but that some people who need after-care may be missed. Circumstances vary to such an extent that this may well be inevitable. We have, however, been impressed by the readiness of the voluntary societies to undertake any work of after-care which lies within their power. We feel that the statutory responsibility of the Local Health Authorities is one that is by no means easy for them to fulfil by direct service, and we have been conscious of the fact that, where the Local Health Authority has recognized to the full the great potential help that the voluntary societies can give, and has invited them to share in their responsibilities, a most useful collaboration has been achieved.

We were interested to find that after-care could include the provision of clothing in cases of need. During the war, and for some time afterwards, parcels of clothing were sent to this country from the United States and the Dominions, and the St. John Ambulance Brigade, the British Red Cross Society and the Women's Voluntary Services became the distributing agents. These supplies have practically ceased but collection of clothing from various sources continues, and many of the clothing stores which these voluntary societies continue to use hold considerable stocks for distribution in cases of need. The work is arduous since all clothing has to be sorted, cleaned and frequently examined to see that it is not deteriorating. A store may be open once or twice a week, and at other times by request; normally clothing is issued at the request of doctors, almoners, health-visitors or social case-workers, who certify that it is needed. Some-

times patients discharged from hospital after a serious illness find that their clothes no longer fit them ; sometimes clothes have been damaged or destroyed in an accident. Men's suits are needed more than anything else. The stores give valuable service to all kinds of people, old and young, and we were informed by the organisers that the need was as great as ever before, even in war-time.

In two kinds of illness after-care is of particular importance ; these are tuberculosis and mental illness. Special attention has been given for many years by voluntary societies and Local Authorities to after-care in both fields of work, and recognition of this is made in Section 28 of the National Health Service Act, 1946, which reads as follows :—

> "28—(1). A local health authority may with the approval of the Minister, and to such an extent as the Minister may direct shall, make arrangements for the purpose of the prevention of illness, the care of persons suffering from illness or mental defectiveness, or the after-care of such persons, but no such arrangements shall provide for the payment of money to such persons, except in so far as they may provide for the remuneration of such persons engaged in suitable work in accordance with the arrangements.
>
> (2). A local health authority may, with the approval of the Minister, recover from persons availing themselves of the services provided under this section such charges (if any) as the authority consider reasonable, having regard to the means of those persons.
>
> (3). A local health authority may, with the approval of the Minister, contribute to any voluntary organisation formed for any such purpose as aforesaid."

In 1947 the Ministry of Health by circular issued a direction under this section that every Local Health Authority should make arrangements for the purpose of preventing tuberculosis and for the care and after-care of persons suffering from tuberculosis, and at the same time invited Local Health Authorities to consider the desirability of making arrangements for the care and after-care of persons suffering from any other kind of illness. Local Health Authorities, therefore, have the duty to provide after-care for tuberculosis patients, but only the power to provide after-care for mental patients.

In the care of patients with tuberculosis voluntary societies have a long record and much valuable experience. The National Association for the Prevention of Tuberculosis, which was founded in 1898, is the only national voluntary society which is devoted solely to this work, but other voluntary societies share in the work. Pioneer work in a rural area was undertaken some twenty years ago by the Kent Rural Community Council ; the St. John Ambulance Brigade, the British Red Cross Society and the Women's Voluntary Services all undertake after-care when their services are needed ; and there are many local groups active in this field of work.

Before 1948 there were Tuberculosis Care Committees in many places, on which both the Local Health Authorities and the voluntary societies were represented, as advisory bodies to the Local Health Authorities, but the extent to which progress was made depended on the readiness of the Local Authority to finance development. In general these Committees have continued their work since 1948.

Treatment of tuberculosis in a sanatorium is lengthy, and a patient who is discharged has naturally become conditioned to hospital life and unaccustomed to normal home life. In some cases the process of readjustment may be difficult. It will not be made easier by the need for limitation of activity; the discipline which this involves will become increasingly frustrating as strength returns. An after-care visitor can help greatly by bringing in new interests from outside, interests which can be pursued without breaking a routine of rest and relaxation, and which can defeat the boredom that a somewhat monotonous existence is likely to produce. The great need is that the visitor should have a lively mind, and should be able to guide and inspire the convalescent to a renewed zest for living. In some cases occupational therapy is of value, and it may help to bring in a small income. Some voluntary societies arrange to sell articles made, and in one city we were informed that a shop had been opened for the purpose to serve a wide region; collection and sales are undertaken by voluntary workers. In other cases correspondence courses have proved to be a stimulus. At the appropriate time the visitor may well be able to help with the finding of suitable employment. Perhaps someone from outside the family can do more to help in these ways than the family itself; after-care visits may lead to a continuing friendship.

After-care of patients suffering from mental illness presents considerable difficulties. Most mental hospitals are still to a great extent shut off from the outside world, and a return to normality may therefore be difficult. The speed and noise which are the background to so much of what is called normal life to-day are symbols of a world of struggle and easily disturb the balance of an unstable mind. A friendly understanding can be an island of security in a sea of frightening confusion. In places where there is an effective after-care service we believe that the readmission rate to the mental hospitals has been greatly reduced.

Before the last war there was some after-care of patients discharged from mental hospitals, but it covered only a small proportion of the people who needed it. The Mental After-Care Association, which was founded in 1879, undertook pioneer work in this field. The Central Association for Mental Welfare, which was set up in 1913 to deal with problems arising from mental deficiency, had in the course of time extended the range of its activities to the field of mental health generally, and in some places undertook after-care through local associations. The National Council for Mental Hygiene entered the field soon after the end of the first war. Following the recommendations of the Feversham Committee in their report published in 1939, the voluntary societies active in this field, except the Mental After-Care Association, agreed in 1943 to a provisional amalgamation under the title of the Provisional National Council for Mental Health. This continued until 1946, when the amalgamation was made permanent under the title of the National Association for Mental Health. The Mental After-Care Association decided to remain an independent society.

In 1944 an interesting and valuable experiment was started, at the request of the Board of Control, by the Provisional National Council for Mental Health and the Mental After-Care Association, when an after-care service for ex-service psychiatric casualties was established. The service was operated throughout the country by teams of psychiatric social workers under the guidance of consultant psychiatrists, and reports indicate that it was an effective service which was capable of expansion. Local Health Authorities which had been in close contact with this service would have made use of it to exercise the powers entrusted to them by the National Health Service Act of 1946, but

unfortunately the Government grants by which the service was financed were discontinued.

Mental after-care is now undertaken by some Local Health Authorities direct, while we understand that others have prepared schemes which have not yet been started. In some places after-care is still undertaken by voluntary societies; for instance, in the area of the London County Council and the County of Middlesex it is undertaken jointly by the National Association for Mental Health and the Mental After-Care Association, while in Cambridge and Sussex there are effective services provided by local associations for mental welfare. We have reason to believe, however, that at present the service of after-care for mental patients is generally far from adequate.

We are impressed by the need for this work to be undertaken by people who are specially fitted for it. We understand that some Local Health Authorities have appointed "Duly Authorised Officers" or "Mental Welfare Workers"; the fact that the "Duly Authorised Officers" are responsible for setting in motion the machinery which leads to certification cannot make their work in after-care easy. In the experimental service, to which we have referred, it became clear from experience that mental after-care could only to a limited extent be entrusted to the untrained social worker acting alone, and that it was necessary to have a combination of psychiatric social workers and social workers under the guidance of a consultant psychiatrist. In one place we have found that the work of after-care was undertaken by a team of psychiatric social workers with special experience under the direction of the staff of a mental hospital which served the district. We believe that the most important factor is the suitability of the person undertaking the work as a person, but we also consider that any lay after-care worker should work under the guidance of a person qualified in the field of mental health.

With the increase in the number of voluntary patients in the mental hospitals the discharge rate has increased also, and there is more after-care for mental patients needed now than ever before. It seems to us that there is a clear need for active co-operation between the mental hospitals, the Local Health Authorities and the voluntary societies. The statutory bodies can provide the money needed to operate a scheme of after-care; the voluntary societies can provide valuable experience, a number of workers trained and qualified in mental health, and many untrained workers who can help with the work under guidance within certain limits.

After-care in the patient's home demands for its success the establishment of a friendly confidence on both sides. The visitor may have to hear at some length the patient's accounts of himself and his problems, and must respond with encouragement and sympathy. The development of an interest which does not cause mental strain, or the finding of suitable employment, may become the visitor's responsibility. Doubtless needs will greatly vary between one patient and another, and often for one patient at different times. The work is arduous, even for a skilled and experienced worker.

For some patients the transition from a mental hospital to the home is too great a step to take, and there is a clear need for homes as "half-way houses." The Mental After-Care Association administers and supervises nearly 50 such homes, but no other society has provided homes to such an extent. We understand that applications for admission to the homes far exceed the vacancies, and that, although patients are only admitted at a doctor's request, a great many applications come also from private sources. This indicates that a great amount of help has yet to be offered if the need is to be met. Indeed, we have come to realise that many more homes are needed in all parts of the country.

For people who as a result of illness or accident become cripples, or who are crippled from birth, there is extensive after-care provided by societies devoted to this specialist kind of work. The Central Council for the Care of Cripples and its many constituent societies provide a full range of after-care services and play a large part in the difficult process of adjustment which disablement makes necessary. Not only are material needs supplied, but experienced workers who understand the psychological difficulties which have to be overcome are available to give personal help and guidance. Voluntary societies of this kind also organise clubs and outings and provide holiday homes adapted for disabled people. A typical example of such work is to be found in a large industrial city where the Cripples Help Society has been in existence for more than fifty years. Starting from humble beginnings it has developed into a substantial organisation with a general welfare department, an occupational therapy department, an employment department, a supplies department, an accounts department and a secretarial department. This society, which has enlisted strong support in its city, has to its credit the founding of an orthopaedic hospital with a department for research. Voluntary societies of this kind exist in many places, and they can make good use of volunteers both for welfare and instructional work and for secretarial work. It should not be forgotten that voluntary societies need secretaries as well as the welfare workers, and store-keepers as well as teachers : abilities of all kinds can be used.

Although it is beyond the scope of this Enquiry we feel that a brief mention should be made of the wonderful work which is being done throughout the country for the blind and the deaf. The National Institute for the Blind, which was founded nearly a hundred years ago, and the National Institute for the Deaf, with their constituent local societies and groups, provide a full range of services of all kinds in conjunction with the Local Authorities, and deserve all possible support.

The work of after-care calls for the best qualities that voluntary service has to offer. It is an essentially human task and represents in a very real way a helping hand to recovery. It is impossible to contemplate that the State could ever provide enough people to meet all needs as part of their professional work. The very essence of after-care is the time that must be given to each patient in such a manner as to suggest that the patient's needs are of primary importance. We believe that in this work the voluntary societies have much to offer, both in valuable experience and in skilled and devoted service, that the State cannot afford to reject.

(c) The Future of Voluntary Service

What is to be the future of voluntary service to the sick and infirm ? What trends can be seen in present developments, and what new opportunities are arising ? It is the principal purpose of our study to find answers to these questions. In order to do this we must first summarise the present position as we have found it and see how voluntary service has succeeded in adapting itself to the seemingly revolutionary changes that were brought about by the National Health Service Act of 1946.

In our introductory chapters we have shown that the National Health Service Act was the culmination of some thirty years of planning, and that its form was shaped over the period of its growth by changing political and social thought. Most people seem to have been unaware of this process of development, and, when the national health service became a reality, there was a general belief, even among people who were closely con-

nected with the voluntary hospitals, that in future the State would do all that was required for those in need of medical and nursing care. So widely was this idea accepted that some of the voluntary societies and groups which had served hospitals for many years closed down, since their members thought that their work for the hospitals was finished. Other voluntary workers found themselves bewildered by the change in authority and by the new financial arrangements, while some felt frustrated and resentful that the work of years seemed suddenly to have been taken from them by the State without, as it seemed, even a backward glance of gratitude. Fortunately, before the stream of public charity and goodwill had ceased to flow, it became apparent that voluntary resource, initiative and activity would be as much in demand as before, and the Ministry of Health made it abundantly clear that the voluntary worker was needed, not only to provide amenities to supplement what the public service would provide, but also to act as the agent of the State in some essential services. Voluntary service was called upon to display what it had always claimed to be one of its greatest sources of strength, its ability to adapt itself quickly to new conditions and to meet new needs with enterprise and vision.

In this chapter we have tried to convey an impression of how this has been done. With a view to giving a fair picture of the present position we have seen not only the large national societies at work in various parts of the country but also small local societies and groups, and individuals, all making in their own way a contribution to a whole. We have also seen a wide range of activity in particular services from, for instance, a residential home for old people to an old woman treated in her home by a voluntary visiting chiropodist. Even so there is much that we have not seen, and there must be many voluntary activities that have no mention in our report ; we have seen no more than a sample of the wares that voluntary service is offering to the public day by day. There is infinite variety in the pattern of voluntary service, and variety also in the performance of set duties. A meals-on-wheels service in one town may be similar in organisation to the same service elsewhere, but it will have its own individual characteristics. The same will be true of out-patient canteens, many of which are distinguished by individual improvisation and lay-out, and even of trolley-shops which, we find, reflect the personalities of their voluntary saleswomen. It is this variety that adds quality to voluntary service, reflecting as it does the imagination and liveliness of mind which creates it, and which, in turn, it hopes to foster.

The new conditions to which voluntary service has had to adapt itself are mainly the result of one fundamental change, the assumption of new and direct responsibilities by the State, including financial responsibilities. Most of the voluntary hospitals of the past, which were "supported by voluntary contributions" not only in money but also in service, are now hospitals in a State service financed from public funds and administered by bodies which, though voluntary, are part of a national system of administration. It may seem that freedom has been lost, but this is largely illusory. Voluntary service has retained its independence, which is its life-blood, and with it its freedom. Moreover, the State, in which the ultimate power now rests, has recognised that without the immeasurable qualities that voluntary service has to offer the hospitals and those whom they serve would lose something that could not be replaced. It survives not for sentimental reasons but for a very practical reason, because it is needed and will continue to be needed. It is now both a partner of the State and an agent of the State in a new

national service, and this presents both a challenge and an opportunity. We have found that the leaders of voluntary societies have tacitly accepted their new rôle and have accepted the challenge also. We have seen little sign of looking backward to the days before the Act and many signs of looking forward. The preservation of independence has kept alive the competitive spirit, but this, while serving as a stimulus to enthusiasm and efficiency, does occasionally discourage co-operation. Loyalty to an organisation is to be encouraged, but not to a point where the organisation becomes more important than the purpose that it serves, and where others working in the same field are seen not as partners but as rivals.

This is a time of difficulty, and yet the conditions which cause difficulty also create opportunity. The difficulties now experienced are not always due to shortage of money; often they are due to shortage of labour, and particularly of women's labour. This significant feature of present-day living conditions is due to various causes of which perhaps the most important is the high rate of employment of women outside the home; a Ministry of Labour report published in 1951 showed that the number of women in employment in 1949 was actually greater than the number employed in 1943, which was the "peak" year for women's employment during the war. This takes many women away from domestic work, either in their own homes or in other people's homes. It increases the need for voluntary service and at the same time it reduces the number of women who are free to give it. The result is seen, for instance, in the field of Old People's Welfare. Old people, even if they can afford it, can no longer buy what they most need, the services of someone to look after them. With improved social welfare material help has become less needed, but personal help has become more needed than ever. In the days of large families there was usually someone young or middle-aged to run the home and to look after ageing parents or any members of the family who were ill. Large families are now rare, and many old people seem to be left completely alone, while home-nursing becomes impossible when all the family go out to work. They could be helped and cared for by voluntary workers, but there are at present not nearly enough people to provide all the help that is needed.

There are then two factors in the present situation which voluntary societies need to take into account. There is the shortage of labour, which means on the one hand that more personal help is needed, and on the other hand that there are fewer people available to give personal help. There is also the apparent paradox that, while the State has greatly increased the provision of material welfare for its citizens and has provided a comprehensive health service which is freely available to all, there is more need than ever for voluntary personal service on what may be termed Samaritan principles.

This interpretation of the present situation gives some indication of the future scope of voluntary service. It is clear that the voluntary service now given in the hospitals should continue, and should be extended to all hospitals. It is clear also that if the hospitals are to be used solely for their primary function, and are to admit and retain only patients who cannot be treated elsewhere, there is much for voluntary service to do outside the hospital in conjunction with the Local Health and Welfare Authorities, far more than is being done at present. These are formidable tasks, and they will involve the recruitment and training of more and more voluntary workers. They will also test the efficiency of the voluntary societies, and their adaptability, since even the basic services must be flexible in organisation and change with changing conditions. Above all they will test the leadership of the voluntary societies, since on this will depend the

maintenance of standards of service, even when work has ceased to be exciting and has become routine. It is easy to say that the future of voluntary service depends on the voluntary societies getting enough of the right kind of people to work for them. It is more difficult to say how this can be done.

We believe that there are a good many people who would readily give some voluntary service if they were asked to do so, but they would include not only people who could give a considerable amount of their time but also people who could give only a little time. There must be be many people who would like to do something useful but who do not know how to set about it. It seems to us that the voluntary societies are too reticent in their publicity, and that active recruitment from time to time, supported by publicity, might produce valuable voluntary workers. Doubtless such a method would also produce some unsuitable volunteers, but careful selection could deal effectively with this. It should be emphasised that the busy worker who can give only a little of his spare time is wanted as much as the independent person who can be used extensively. Any recruiting of this kind should, of course, take into account the particular needs of the time, since it would be a mistake to recruit a large number of volunteers and then find that there is no job for them to do. As expansion proceeds recruitment should follow.

We believe that it should be generally recognised that there are now few people who can give a great deal of time but many people who can give a little time, and that voluntary societies now have to make use of whatever help is available, even if it creates difficult problems of organisation. This is normally appreciated by voluntary societies, but we think it is less appreciated by the general public, and that there must be many people who would readily volunteer but who feel that it is not worth their offering their services for only a few hours each week.

There must also be people who feel that they have nothing to offer, and we believe that it is important that it should always be emphasised that skills of all kinds are of value. St. John Ambulance Brigade and the British Red Cross Society have always acted on the assumption that all the nursing skill is not employed in the nursing profession, and have shown that women can be trained in a short period to serve efficiently as auxiliary nurses. The Women's Voluntary Services and the other societies, have shown in the diversity of their work, that good use can be made of people with organising ability, people who can work as secretaries, accountants or store-keepers, librarians, car-drivers, cooks, people who can entertain, musicians, artists, craftsmen, and many others. One organiser of a voluntary society told us that she could wish for nothing better than a woman who had all the virtues and skills of a good housewife. In fact there must be few people who are unemployable. In 1940, when we were threatened with invasion, there was an overwhelming response to appeals for voluntary help. Is it too much to hope that people can be made to realise that although the need is less apparent now it is in its own way as great?

We think that there should be a more universal acceptance of the principle that the out-of-pocket expenses of voluntary workers should be met. In the past no doubt there were many people who could afford to give their time and pay their expenses, but times have changed. Voluntary societies have rightly clung to the proud traditions of voluntary service, but we have found from experience that there are people who are paying from their own pockets substantial amounts each week in travelling and paying for meals away from home. We think it likely that there will be some who will give up their work on some pretext rather than give the real reason, and some delicacy of handling

may well be necessary. If it were the normal rule that out-of-pocket expenses were refunded it would, in our view, increase recruitment and save much embarrassment and personal strain.

The voluntary societies appreciate the importance of training their voluntary workers for work in hospitals and in the care of the sick and infirm in their own homes. Training courses and conferences are a regular feature of their national and local programmes. Much is to be gained from the pooling of experience, from instruction and direction on matters of universal application, and from the teaching of such technical aspects of the work as there may be. Such training gives confidence and maintains standards.

It is important to look ahead, and we have been impressed by the value of the cadet units of St. John Ambulance Brigade and the Red Cross Society. In these units boys and girls are taught the principles of first-aid and home-nursing, and in regular meetings they find the opportunity of developing qualities of leadership. Many of them will in later years become skilled and reliable members of the adult societies. Some will be encouraged to enter the medical and nursing professions, and some will have their first taste of adventure as cadets. We have seen cadet units of both societies and have been much impressed by their liveliness of interest, by their skill in practical demonstration, and by their general bearing and sense of responsibility. In talking to cadets we came to realise how much practical experience many young people have in their own homes. Almost all the members of a girls' unit in a mining village had had nursing responsibilities at home ; one girl of 13 had nursed her mother for six months. The development and training of these skills is of great importance, and we commend the work of these cadet units and of the men and women who give voluntary service as leaders and instructors. There is no doubt that these units are making a real contribution to youth work generally.

We have shown in our report that the voluntary societies are not standing still, and that they welcome new opportunities for pioneer work. Stimulation to fresh enterprise, and the chance to use initiative, help to preserve vitality in a voluntary society. New ideas sought for this purpose alone, or for the less worthy purpose of self-preservation, are of little real value, but fortunately the care of the sick offers scope for development and diversity, and the range of services that are needed has by no means been exhausted. We feel that the voluntary societies are wise in encouraging their district organisations to develop individually and to experiment as opportunities occur. We hope that they also encourage their individual workers in the field to bring forward new ideas, since it is those who work most closely with their fellow-men who should see most clearly what needs to be done. We believe that the vitality of any society depends not only on leadership at the centre but also on fertility of ideas and resourcefulness of even the most humble workers in the field. We have seen many examples of resourcefulness, and this makes us believe that the ideas are there also.

We have already suggested that there may be great opportunities for new development in the field of mental health, and we have shown how some mental hospitals and voluntary societies, such as the National Association for Mental Health, are striving to educate the general public to a new concept of mental illness. The breaking down of barriers between the patient with mental illness and his fellow men outside the mental hospital is a formidable task, since the fear associated with the "lunatic asylum" is deeply rooted. If the present work of education is to gain ground, somehow this fear must be banished. The voluntary worker who is frequently in people's homes can do much to help in this task. Technical knowledge and experience of mental treatment are not

needed ; a common sense and quite humble, non-technical, approach will succeed when other methods fail. People must learn that mental illness is no more to be feared than physical illness, and that the "lunatic" should no longer be regarded as an outcast. That progress is being made is shown by the increasing number of voluntary patients. Even so there must still be many people who will seek treatment only when it becomes unavoidable, and then perhaps it is too late. Every social worker is familiar with the family tragedies caused by one member suffering from "nerves," as it is so often called. If help could be given early, to the family as well as to the sufferer, the pressure on the mental hospitals might well be reduced in a short time. There is scope for new ideas and for experimental work. At present two out of every five hospital beds are occupied by mental patients, and still there are not enough. Can the number be reduced by constructive and preventive work? This presents a challenge to all concerned with mental health and mental illness, not least to the voluntary societies.

Another field of opportunity lies in work for the young chronic sick. Here is real tragedy, intensified by the situation in which so many of the sufferers find themselves. Is it beyond the range of possibility to give these poor people, who are condemned to a bed of sickness until death, the chance of such few pleasures and interests as they can enjoy? Must so many continue to suffer in the sole companionship of the senile? Here is another challenge which the voluntary societies might well accept. The pioneer work of voluntary societies has often educated public opinion and influenced national policy, and it can do so again.

So far we have written of the future of voluntary service in terms of the voluntary societies. We have done so because, with the new basis of agency, the voluntary societies have naturally become the mainspring of voluntary endeavour. Individual initiative and individual service have not, however, vanished, and it would be a grave loss if they should ever do so. Few things that we have seen have given us more pleasure and encouragement than two examples of individual voluntary action unrelated to any voluntary society.

One of these is the Scunthorpe Remedial Recreational Club, in Lincolnshire, which has as its aim "the resocialisation of the sick or injured by the activities of a club of which they hold temporary membership." The club has a membership of about 50, of whom one-half are patients who have recovered from poliomyelitis ; about half the members are children and half are adults. The club meets twice each week ; once in a gymnasium where games, handicrafts, social and recreational activities are arranged, and once at a local swimming bath, where swimming sessions are followed by refreshments. Temporary membership is insisted on, however prolonged the period of readjustment, since the club is intended as "a bridge between the hospital environment and normal society." This remarkable club was started by the orthopaedic surgeon and the almoner of the local hospital—an impressive example of voluntary service by professional people—and they are helped by an enthusiastic band of voluntary workers, which include some other professional people. The swimming activities are in the hands of a rota of voluntary workers from the swimming club and from other local organisations. No-one who visits the club can fail to be impressed not only by the physical readjustments made but, perhaps even more, by the atmosphere of vitality and enthusiasm which is the measure of its success in mental readjustment to normal life. It is to be hoped that this club will quickly succeed in its efforts to collect the money which is needed to provide its own buildings, so that in its pioneer work it may have every chance to lead the way. Such

work shows that in the field of rehabilitation there is much room for development, quite apart from the admirable work undertaken by the Ministry of Labour in its Industrial Rehabilitation Units.

The other example of individual achievement is a home at Liss in Hampshire called "Le Court"—the Cheshire Foundation Home for the Sick. This home was started by a young man, Group Captain G. L. Cheshire, who was an "air-ace" of the war, decorated with the V.C., the D.S.O. and two bars, and the D.F.C. and bar. As a result of personal experience he decided to devote himself to providing a home for sick people for whose special needs the national health service could not provide, and who had nowhere else to go. It was to be a home in the sense of a family, and all who were there, staff and patients, were to live a community life helping each other to the best of their ability. Any person in need of such a home was to be admitted, regardless of age, sex or complaint. The home has at present 32 patients whose ages range from 18 to 92, but in future preference is likely to be given to younger people who would otherwise have to be in chronic sick hospitals. It is believed to be the only home that provides for the young chronic sick the opportunity to lead as normal a life as they are able to lead, with all the nursing care that they need. Experience has made it necessary to refuse admission to patients suffering from tuberculosis, but this is the only exception. Advertisement has never been necessary, and the home is widely known by almoners and others responsible for placing patients. Applications for admission come from both official and private sources in a steady stream, and all but a few have to be refused. A second home has been opened by the Foundation in Cornwall, but the demand shows that many more such homes are needed. Patients pay fees, but their fees are not nearly large enough to cover the cost. Starting with personal financial responsibility, at great sacrifice to the founder, the home has received private subscriptions and grants from King Edward's Hospital Fund which have enabled its debts to be paid, but continuing financial help will be needed. The house needs repair, and the rooms lack many of the comforts and amenities which are needed. Despite these conditions there is courage and cheerfulness and a wonderful spirit which pervades this remarkable little community of people whose burdens of illness must be most difficult to bear. It is a most gallant, if unorthodox, enterprise, and it too points the way to a new line of pioneer work of immense value.

It is a significant feature of much voluntary social work in our time that it is concerned not with one or more particular forms of social welfare but with the whole condition and circumstances of a person's life. At one time the need for material relief was so great and so obvious that all other considerations tended to be excluded. Now voluntary service can deal with underlying problems which cause anxiety, distress and sickness, as for instance loneliness in old age, family relationships in the living conditions of to-day, adjustment to normal living and to work after illness. To find solutions to such problems it is necessary first to have a deep understanding of them, and it is by no means easy for people who are continuously busy in the organisation of voluntary service to have the time to study such problems intensively and extensively. We feel that one of the tasks of voluntary service should be to keep continuously aware of the changes which affect human life, and to study the effect of such changes on people. Only through careful observation can the real needs of people be seen. In each age some problems are solved. It is sometimes forgotten that in each age new problems are created. In its function of pioneering voluntary service must always be exploring unknown territory.

One of the most significant features of voluntary service to-day is that voluntary workers come from all social groups. In a few voluntary societies there is perhaps an element of social distinction, but it is not marked, and in general it would be true to say that "all sorts and conditions of men" are to be found as voluntary workers, and that selection for positions of leadership and responsibility is not now dependent on social qualifications. How different this is from the position a hundred years ago when people could be roughly classified in two groups based on social distinction, those who might be expected to do good to others and those to whom good was done !

Leadership in a voluntary society is so important that it has had many a special study. Two kinds of leadership are needed, leadership at the centre and leadership in the field. In voluntary societies there is no element of compulsion, except the compulsion of personality. Leadership at the centre requires organising ability, imagination and the capacity to inspire loyalty. The greatest of those who lead at the centre of the voluntary societies are people of outstanding personality and ability who command the highest respect not only throughout their own organisation but in the nation generally, and it has been interesting to observe in our work the extent to which their personalities have impressed themselves on all who serve with them. Leadership in the field requires above all a deep understanding of one's fellow men, since it is only through such an understanding that the team-work on which most of the voluntary activities depend can be created. The leader must be constantly and instinctively aware of the sources of cohesion and of tension in the group in order to strengthen the one and ease the other. The leader must identify himself with the group, setting standards of reliability and efficiency with no studied display of either, and must be a person who will take responsibility for decision, even when there is a risk of failure, without seeking personal credit when credit is due. This may suggest that successful leaders in voluntary societies are exceptional people. We believe that they are, and that, while leadership in voluntary societies is as stern a test of the qualities of a leader as any that can be found, the work brings out those qualities in a remarkable way, often in people who would not have been expected to possess them.

There should be no place in the voluntary societies for promotion by seniority, a system which, except in the higher posts, is general in the public service. In such a system initiative and enterprise involve the risk of failure and consequent loss of promotion. In the voluntary societies initiative and enterprise are rewarded ; there must, by the nature of much of the work, be failures, but it is often through failures that the way to success is found. It is only inactivity that can produce no results.

It is the scope for initiative and enterprise, the opportunity to experiment with equal chances of success or failure, and the chance to follow a vision and to see where it leads, that keep the spirit of voluntary service alive. If voluntary service is to serve the nation with full measure this must be recognised by those who administer the public service with which it works. Its activities may fail to conform to accepted procedure, and may create administrative problems, but this should not be the test of their worth. Given the chance to work in its own particular way it will bring vitality to whatever it touches. If it is brought "into line" it will stagnate. In this there is both a warning and a challenge.

PART IV

CHAPTER VI

VOLUNTARY FUNDS

(a) Hospital Endowment Funds and Samaritan Funds

To give money to a worthy cause is a form of voluntary service : indeed, as we have shown earlier in this report, there was a time when charity was an accepted obligation of the privileged classes while the kind of personal service which is a notable feature of our time was hardly known. To those who gave their money generously in the eighteenth and nineteenth centuries we owe many of the voluntary hospitals which, now transferred to the State, make an important contribution to the national hospital service. Not only were hospitals built, but most of them were endowed as well. These endowment funds may in their early days have been large enough to meet the costs of maintaining the hospitals ; as time went on the costs increased enormously and it was necessary for the voluntary hospitals to seek further financial help from private subscriptions. Up to 1948 the phrase "supported by voluntary contributions" was familiar to us all.

When in 1949 it became clear that in creating the national health service the government intended to provide for the transfer of the voluntary hospitals to the State, there was naturally some concern about the future of the endowment funds, and representatives of the voluntary hospitals made the claim that they should be retained by the hospitals for whose benefit the money had been provided. This claim was accepted in part only, and in the National Health Service Act of 1946 a distinction was made between the voluntary hospitals that were teaching hospitals and those that were not. Under Section 7 of the Act the endowment fund of any voluntary hospital that was designated by the Minister as a teaching hospital was to be vested in the new Board of Governors, to be "held by the Board on trust for such purposes relating to hospital services or to the functions of the Board . . . with respect to research as the Board think fit." Under the same Section the endowment funds of all other transferred voluntary hospitals were to be vested in the Minister, who was to establish with them a fund to be called the Hospital Endowments Fund and to make regulations providing for the control and management of this fund, for apportioning the capital value of the fund among the Regional Hospital Boards and Hospital Management Committees, and for distributing the income of the fund to the Boards and Committees proportionately to their shares. Each Board and Committee was to be free to use the money so allocated "for such purposes relating to hospital services, or to the functions of the Board or Committee . . . with respect to research, as the Board or Committee thinks fit," securing as far as was practicable that the particular wishes and intentions of their former benefactors were observed. One concession was made ; under Section 59 of the Act Regional Hospital Boards and Hospital Management Committees were empowered to accept gifts and to use the money given for the benefit of the hospitals or for research, thus making possible the continuance of private charitable subscription to hospitals in the national health service.

Since 1948 there has been some uncertainty about the use of these funds. Some of the teaching hospitals hold very substantial endowment funds, and their Boards of Governors have found it difficult to decide how best to make use of them in ways which would accord with the wishes of the original benefactors. Since the State had accepted responsibility for the normal expenditure of the hospitals there seemed no point in using the hospitals' own money for any such expenditure; it would take time to expand research and it did not need the expenditure of a large sum of money each year; and to spend lavishly on amenities for the hospitals could hardly be justified. In fact there has been much variation in the use of these funds. In a few cases money has been used to purchase essential equipment which should have been provided by the State in order to save delay which would be caused by the need to obtain official approval. In some cases substantial sums of money have been used in the provision of amenities for patients and hospital staff. A good deal of money has been spent on improving facilities for research. Some teaching hospitals have sent members of the medical staff overseas to observe new techniques, and one hospital has arranged for newly appointed members of the staff to undertake such visits before taking up their duties at the hospital. There appears to have been no common policy in the use of these funds.

The non-teaching hospitals have received from the Hospital Endowments Fund small payments of income calculated on the basis of the number of beds. The first payment, which was for a nine-month period, amounted to about 30s. 0d. per bed. Subsequent payments have amounted to something like 35s. 0d. per bed. With this income alone the Hospital Management Committees can provide little in the way of amenities for patients and staff. As already stated, hospitals are permitted under Section 59 of the National Health Service Act to receive gifts, and somewhat naturally a number of hospitals sought to increase their amenity funds by money-raising efforts in their localities. The Ministry of Health thereupon issued on 18th December, 1948, a circular directing that such practices should cease. The circular added that while such bodies as "Friends" of hospitals were free to make their own appeals for funds it was essential that they should be, and should be seen to be, wholly independent of the hospital boards and committees, and that members or officers of the committees should not take part in their activities. The Ministry pointed out that in taking this line they were not seeking to discourage voluntary effort in any way and that "voluntary service should be encouraged in all its forms." The issue of this circular caused a certain amount of indignation, and the view was widely expressed that it was illogical that hospitals should be permitted by Act of Parliament to hold and administer privately subscribed funds and be prevented by the central authority from asking the public to subscribe to them. It was, however, appreciated that members of the public might well resent being asked for voluntary subscriptions to hospitals in a national service whose expenditure was met from Exchequer funds to which they contributed through taxation and insurance contributions. Direct appeals to the public have therefore ceased, but many hospitals have the active support of such bodies as "Friends of the Hospital," support which has been stimulated by a central body called "The National League of Hospital Friends."

Hospitals still receive legacies and donations by covenant although it is probable that the total amounts received from these sources have declined since 1948 and will further decline. Legacies have already caused legal complications, and test cases have been necessary, as a result of which it has been established that money left to a particular hospital which was a voluntary hospital and was transferred to the State under the Act

shall be placed in the hands of the Hospital Management Committee concerned, but on terms that confine the direct benefit to the particular hospital. Subscriptions paid under seven-year covenants entered into before the transfer of the hospitals have also caused difficulties. It was ruled that such subscriptions became part of the hospital's endowment fund and these, in the case of a non-teaching hospital, had to be paid to the central Hospital Endowments Fund. In some cases subscribers cancelled payment, and early in 1951 the Ministry of Health sent letters to these people reminding them of their legal obligation and asking them to send their cheques direct to the Ministry. It was unfortunate that this action had to be taken since it must have offended some generous benefactors.

Although they are now part of a national service which is financed from Exchequer funds, hospitals have, therefore, funds of their own which can be used at the discretion of the Board of Governors or Hospital Management Committee. The amount of money in these funds varies enormously. The teaching hospitals, through retaining their original endowment funds, have larger funds than the non-teaching hospitals, but even among the teaching hospitals there is great variation. Some have very large funds at their disposal while others have never had more than a small endowment. Among the non-teaching hospitals those which were formerly voluntary hospitals with strong local support will be in a better financial position than mental hospitals or hospitals for the chronic sick which were formerly Public Assistance Institutions. It is to be hoped that people who want to help hospitals with gifts of money will be as ready to help hospitals of this kind, where the need for amenities is usually very great, as they are to help hospitals which in the past have been assisted by voluntary contributions.

One benefit that should come from the right use of these funds is the preservation of individuality. In a national service there is always a tendency towards standardisation. "Free money," as it is often called can give each hospital individual characteristics which help to create an individual atmosphere. It is arguable that public funds should not be used for this purpose, and that an equal standard should apply to all. As things are, local interest can still be reflected in the material condition of the hospitals even though hospitals are no longer dependent on local interest and financial support for their continued existence.

It has been suggested to us that it would be sound policy for the State to undertake only such financial responsibility for the hospitals as would meet the cost of maintaining basic minimum standards, and that the cost of anything in excess of these basic minimum standards should be met from voluntary contributions. The intention behind this suggestion was that it would keep alive the keen local interest whch found expression in the old days in the organisation of hospital weeks, fêtes, flag-days, bazaars, etc. We do not believe that this would be sound policy. Even if basic minimum standards could be determined satisfactorily, which seems very unlikely, such hospitals as mental hospitals which have no local connection, and many of the former municipal hospitals, would be likely to get little or no more than the basic minimum standards while former voluntary hospitals would get all the amenities that they wanted. We believe, moreover, that keen local interest is not dependent for its survival on the raising of money, and that it can remain strong and active if it is encouraged to find expression in voluntary personal service to the hospital and to the sick and infirm of the district.

Endowment funds and "free money" can be used for the benefit of the patients in the hospital and hospital staff, but cannot be used to help individual patients in cases of

special need. Many hospitals have for some years had what are usually called "Samaritan Funds" for purposes of this kind and for helping with the costs of convalescence for patients who cannot afford to meet them, and these funds were usually administered by the Board of Governors of the hospital. The present position of these funds is somewhat obscure, but it appears that in general the hospitals have retained them and have been administering them much as before. In a circular issued on the 7th March, 1950, the Ministry of Health set out the legal position of such funds and indicated that for legal reasons it appeared to be desirable that they should be administered not by Boards of Governors and Hospital Management Committees but by separate bodies of trustees. Boards and Committees were asked to regularise the administration of their funds if their present administration was irregular. By implication the continuance of such funds was approved. They are in fact of great value, and every hospital almoner can quote cases in which a Samaritan Fund has been the only source from which a genuine need could be met.

In our view it is good that people should still be able to give money to hospitals, and we feel that they will be encouraged to do so if they are told how the endowment funds and Samaritan Funds are used. If they are shown that they are not paying twice for the hospital service, once through taxation and once by voluntary contributions, we believe that they will appreciate the chance to contribute something which cannot be provided from public funds but which will be to the benefit of their own hospital and will preserve its individuality even within a national service. In such a way a grateful patient, who can afford to give, will be able to show his gratitude. As a recent article in *The Economist* on certain aspects of this subject said: " . . . . charity is not only a matter for the recipient. A country can only lose if a source of charitable expression is blocked. It can only gain if the link between the charitable impulse and all the yet unexplored opportunities around a hospital is restored."

(b) Charitable Funds

There are many charitable funds devoted to the care of the sick and infirm. Some of these are of old foundation, belonging to the great period of private philanthropy, but they survive because the need for private charity still exists even though there is a comprehensive health service available for all who need it. Some of the funds give direct help to individuals in need; some provide money for the provision of convalescent homes, homes for old people, help for the disabled, help for ex-service men and women, and other activities of this kind; others provide money for research.

In the field of hospitals the two most important and influential charitable funds are King Edward's Hospital Fund for London and The Nuffield Provincial Hospitals Trust. Since these two funds play an important part in connection with the hospital service we think it appropriate to give some information about their history and their activities.

King Edward's Hospital Fund for London was founded in 1897 as a result of a widespread desire to commemorate the Diamond Jubilee of Queen Victoria in a way that would provide lasting benefits for the community as a whole. In 1907 the Fund was incorporated by Act of Parliament with its objects defined as "the support, benefit, or extension of the hospitals of London." From the start the Fund based its administration on three principles: first that its existence should not be dependent upon current income from subscriptions, donations and legacies, but should be securely founded upon accumulated reserve funds; secondly, that its influence on the voluntary hospitals as a grant-

aiding body should be used benevolently but firmly with a view to increasing the efficiency of the hospitals; and thirdly, that it should be a fund not only of money but also of knowledge and experience in hospital management to which the hospitals might turn for advice.

The last of these three principles came to be regarded as of increasing importance as the years went by. It was fulfilled not only by building up a staff of paid and experienced experts in hospital management, but also by making use of the voluntary services of men and women with special knowledge of hospital affairs. Experience showed that teams of "visitors," consisting of one lay and one medical member, were best able to assess the needs and efficiency of the hospitals. All appeals to the Fund for financial assistance towards the cost of routine maintenance, or of capital improvements, were examined by these teams and, although conditions have changed as a result of the transfer of the hospitals to the State, the same procedure, appropriately adapted, continues to operate. Through the work of its expert staff and the work of its visitors the Fund has established itself as a recognized authority on hospital management.

In the years before the National Health Service Act came into force there were broadly two sides to the Fund's work. Its primary function was still the support and improvement of the voluntary hospitals of London by means of monetary grants—the annual rate of distribution had risen from £50,000 in King Edward VII's time to over a quarter of a million pounds in 1936. The other side of its work lay in making an indirect contribution to the hospitals in various ways. In 1928 it introduced a superannuation scheme for nurses and hospital officers throughout the country; in 1929 it acted as representative of the voluntary hospitals in negotiations with the Local Authorities on methods of co-ordination of the voluntary and municipal hospitals; it issued important memoranda on hospital management and policy, and took a responsible and effective lead in hospital affairs generally.

When the National Health Service Act came into force in 1948 the Fund was relieved of the function of financing the London voluntary hospitals, except for those which were not transferred to the State. It was quickly appreciated that this would provide an opportunity for the Fund to divert its financial resources into other channels, and to develop the activities which made an important but indirect contribution to the hospitals to the point where it would be regarded as a national centre of expert advice and information on hospital affairs. There were many tasks which the Ministry of Health and the Regional Hospital Boards had not the resources, either of money or experience, to undertake, particularly in the training of non-medical hospital staff. Even before the Act came into force a start had been made in the training of ex-service men with administrative experience for future posts in hospital administration. The success of this training scheme encouraged the Fund to provide a Staff College for Hospital Administration. This college, which was opened in 1951, provides residential courses and also acts as a centre for thought and research on hospital problems. This was not the Fund's first experience of a residential training scheme since it had established in 1949 a Staff College for Ward Sisters where selected nurses take three-month courses in preparation for their future appointments as ward sisters. Hospital catering is another sphere in which the Fund has been active. A dietetic advisory service was started in 1943, and a training centre for hospital catering and cookery has recently been opened.

King Edward's Hospital Fund operates the Emergency Bed Service for London on behalf of the four Metropolitan Regional Hospital Boards. This is a "clearing-house"

for dealing speedily with the admission of emergency cases to the London hospitals. A day and night telephone service is provided, and some 5,000 applications are dealt with each month. It also operates a nursing recruitment service which helps to maintain quantity and quality in the nursing profession, and it maintains a library and information service on all hospital matters, particularly those relating to finance and equipment.

Since the new hospital service has been in operation it has become increasingly obvious that there is at present no satisfactory basis on which the administration, and in particular the financial administration, of one hospital can be fairly compared with that of others. The lack of basic standards has not encouraged the central authority to give to the Regional Hospital Boards and Hospital Management Committees that measure of financial autonomy that Parliament intended them to have. In view of this the Minister of Health in 1950 asked King Edward's Hospital Fund and the Nuffield Provincial Hospitals Trust to examine jointly the possibility of producing a "standard cost" for all hospitals on which fair comparisons could be made. It is no easy task, and it is encouraging that the statutory authority should invite these two voluntary bodies to undertake it, and that their specialist experience should be used for the benefit of the hospital service.

Monetary grants are still made to hospitals, not only to disclaimed hospitals which still rely on voluntary funds, but also, in some cases, to hospitals in the national service towards the cost of developments and improvements which cannot at present be financed from public funds. Substantial grants have also been made to convalescent homes serving the London area, and a large sum has been allocated to the provision of "half-way homes" for the aged sick. The money that was previously needed for the maintenance of hospitals is thus being used to help in the solution of new problems that have arisen to which solutions must at present be found outside the national health service. It therefore continues to be a valuable central fund by which individual charitable contributions can be used for the benefit of the sick and infirm, and a pioneer in new development.

The Nuffield Provincial Hospitals Trust was founded by Lord Nuffield in December, 1939, with an endowment of one million share units in Morris Motors Ltd. The purposes of the Trust, in the words of the trust deed, are : "the co-ordination on a regional basis of hospital and ancillary medical services throughout the provinces and the making of financial provision for the creation, carrying-on or extension of such hospital and ancillary medical services as in the opinion of the Governing Trustees are necessary for co-ordination." It should be remembered that in 1937 the need for co-ordination of the voluntary hospitals and of the establishment of a scheme of co-operation with the municipal hospitals had been strongly recommended in the report of the Sankey Committee set up by the British Hospitals Association. It was the intention of the Trust to achieve so great a measure of co-ordination that in time a truly national hospital service might be evolved, "which would embrace all that is best of both public and voluntary effort, with the maximum of economy to the State and to the private purse."

The Trust set out to establish advisory machinery which, it hoped, would bring together the hospitals within a given area in full partnership without prejudicing their individuality. The basis of the plan was the division of the country into a series of hospital regions, each having as the focus of the hospital and health services a university medical school, a pattern which was later used for the administration of the national hospital service established by the National Health Service Act of 1946. The war prevented the development of this plan, and in 1941, after the Government's declaration

of policy in the House of Commons, the Trust was asked to suspend its activities in order to avoid administrative difficulties. A start had already been made and some regional councils were already established. By 1948, when the new hospital service came into operation, about half the country possessed advisory councils of various kinds.

During the war, when the Ministry of Health found that their creation of an Emergency Medical Service was hampered by lack of detailed information about the hospitals, the Nuffield Provincial Hospitals Trust undertook for them the organising and financing of surveys of provincial hospitals, and the reports were of great value not only for wartime purposes but also in the shaping of the national hospital service.

The Trust was also making money grants to hospitals and ancillary medical services. Up to 1945 block grants were allocated to the regional and divisional councils set up by the Trust which generally used the money in grants to individual hospitals. From this date the Trust's policy was altered and it was decided that its funds should in the main be used to support experimental projects. The Trust had already anticipated this policy by establishing in 1942 the Chair and Institute of Social Medicine at the University of Oxford, and two experimental bureaux of health and sickness records, at Oxford and Glasgow. Further substantial grants were made to these, and in 1947 a new project, the Slough Industrial Health Service, which aimed at providing a comprehensive service for a group of small firms, was established. The Trust also financed important projects in child health and mental health, establishing a Chair in Child Health at the University of Durham in 1942, and at the University of Belfast in 1948, and in 1946 a Chair of Psychiatry with a complete psychiatric unit at the University of Leeds. The University of Manchester was helped to extend its neurological department, and grants were made for the appointment of a medical neurologist at Oxford. Grants were also made for developments in plastic surgery at Oxford, for research at Manchester into the education of the deaf, and for penicillin research. In the field of hospitals the Trust provided substantial funds to extend to the provinces the work of recruitment of nurses on the lines of the centre established in London by King Edward's Hospital Fund.

Since 1948 there has been some change in the emphasis and method of the Trust's work, which is now concerned not so much with grant-aiding pioneer experiments by other bodies as with the Trust's own studies, experiments, and demonstrations. In seeking ways to improve the service to the patient the Trust has found that much of the basic information is missing ; in the place of accepted data and verifiable facts there are often only conflicting opinion and impressions—about, for example, the work of the nurse, the function and design of hospitals, or the best form of health-centre. For the first two the Trust has set up its own teams to investigate and report ; experiments to test their findings, by building ward-units designed for different routines of ward work, will follow. For the third, health-centres, the Trust has three different experiments in hand, and others in mind, so as to compare various methods and types. But as health-centres cannot yet be generally provided, the next best thing—group practice by family doctors—is also being studied to see what are the advantages, to patient and practitioner, and whether the benefits could be more widely applied. To studies such as these, pursued not for their academic interest but with a view to practical testing and demonstration of possible improvements in the service to the patient, the Trust is now devoting the major part of its interest and its income. Thus the Nuffield Provincial Hospitals Trust is active in experimental work of the kind that cannot easily be financed from public

funds, and is exploring the way ahead so that the national service may in its advance tread on firm ground.

The number of smaller charitable funds designed to benefit the sick and infirm is at present not known. The fact that a survey showed that there were some 5,000 charities for help to old-age pensioners, with an annual income of 5 million pounds, may be some indication of their extent. These charities are mainly local funds applied to local needs. Changing conditions sometimes make their objects inappropriate or no longer necessary. In some cases only minor adjustment of policy is necessary; for instance, while the Metropolitan Hospital Sunday Fund used, until 1948, to make grants towards the maintenance costs of the London hospitals, its council has now decided to use its available income by making grants to hospital Samaritan funds. In other cases the whole object of the fund has ceased to exist, and in June 1949 Lord Samuel proposed in the House of Lords that in these cases the funds should be aggregated and the income disbursed as "Common Good" funds in grants to voluntary societies and local groups, the funds being supplemented by dormant balances in the banks, that is, money whose owners cannot be traced. A committee under the chairmanship of Lord Nathan was set up to examine the position and consider these proposals, but it has not yet completed its report.

The intention behind Lord Samuel's proposals was that additional money should be found outside Exchequer funds to help towards the increasing working costs of the voluntary societies. In the last chapter we showed that there was a need for more and more voluntary service to the sick and infirm, and for the selection and training of more and more voluntary workers. All this will involve the voluntary societies in increased expenditure, and it cannot be undertaken unless they can increase their annual income. When acting as agents of the State they can, of course, have their expenditure met from public funds, but much of their service is given direct and of their own volition, and for this they must meet the expenditure from their own funds. If existing charitable funds which are at present not used could be diverted for this purpose they would be put to good use. Even so voluntary service would still depend for much of its income on private subscription, and it is to be hoped that people who can afford to do so will subscribe not only to hospitals and the charitable funds but also to the voluntary societies and local groups which, as we have shown, give invaluable service to the sick and infirm.

We believe it to be important to society that there should always be charitable funds that are free to use the money that they hold in trust without the restriction of official regulations. In a State service experiment is not always possible since the expenditure involved must be justified in advance. There must be experiment if there is to be progress, and it must be one of the prerogatives of voluntary service to undertake the pioneer work. In this way, and in other ways, voluntary service can guide national policy. Such large charitable funds as King Edward's Hospital Fund for London and the Nuffield Provincial Hospitals Trust by the wise use of their funds exercise a considerable influence on hospital policy.

The word "charity" has come to mean the payment of money to people who are in need of help. Much of what used to be described as "charity" is no longer necessary in a society which accepts basic standards of welfare for all its citizens. An older meaning of the word was "care for one's fellow-men." We believe that those who administer the charitable funds see their responsibilities in this light, and continually seek to use the money entrusted to them for human betterment.

(c) Hospital Contributory Schemes

An important element in hospital finance before the National Health Service Act came into force was the income derived from hospital contributory schemes. The Cave Committee in their report issued in 1921, commended the way in which some hospitals were supported by weekly contributions of a few pence from working men and women, and advocated the extension of such schemes. There was a rapid advance as hospital contributory schemes were established in many parts of the country, some connected with single hospitals and others, such as those in London and in the large provincial cities, connected with groups of hospitals. In 1930, on the initiative of the Birmingham Hospitals Contributory Association, a conference of representatives of contributory schemes was called, and this conference took steps to form a national association which was given the title of "The British Hospitals Contributory Schemes Association."

The total income of the contributory schemes was very substantial. By 1935 the income of 114 schemes making returns to the British Hospitals Contributory Schemes Association was over 2½ million pounds a year, received mainly from subscriptions of 2d. or 3d. a week from some 5 million contributors. In some places employers contributed also in proportion to the number of their employees contributing. By 1943 there were nearly 200 schemes in membership of this Association, with a subscribing membership of nearly 10 million and an annual income of 6½ million pounds. There were also other schemes, some of which had substantial income, which were not affiliated to the Association. The contributory schemes had therefore become very substantial subscribers to the funds of the voluntary hospitals, and this had earned them the right of representation on many hospitals' Boards of Governors.

Subscribers and their dependants were entitled to free treatment in the voluntary hospitals, and generally, by arrangement, in the municipal hospitals also. The schemes of benefit varied but normally covered specialist treatment and convalescent home treatment. It was, however, an accepted principle, of which the importance was emphasised by the Cave Committee, that subscribers to contributory schemes should not be given priority in admission to hospitals over non-subscribers. The schemes filled a gap which had been left by reason of the National Health Insurance Scheme being limited to the general practitioner service for insured workers only, and not therefore covering hospital treatment or the treatment of dependants.

Since the contributors were in a position to receive benefits themselves as a result of their contributions, it can be argued that their payments could not be described as personal charity. This was not the view taken by the British Hospitals Contributory Schemes Association. The members of the Association were concerned to keep in being a voluntary system that would be of benefit not primarily to the contributors but to their fellow men and women. At one of their conferences their President, Sir Bertram Ford, said: "The whole object of contributors is not to get all they can out of the scheme, but to give, and to give freely, while they are in health and in work, bearing in mind that if they do not suffer themselves what they are giving will go to help those who do suffer."

In 1948, when the National Health Service Act came into force and brought to an end the need for voluntary effort to maintain the voluntary hospitals, the Association was dissolved. A number of the contributory schemes decided, however, to remain in being with a view to providing for their members benefits which would supplement what the

national health service would provide for them. These schemes formed a new association which was given the title of "The British Hospitals Contributory Schemes Association (1948)." At the general meeting in 1949 the chairman, Mr. Henry Lesser, said: "We are certainly not satisfied that there are no gaps in the national health service which cannot be filled by voluntary effort and contributions. We want to encourage contributors to continue paying contributions. We feel that we are doing a valuable national service by encouraging this effort."

Experience has shown that there were gaps to be filled, and the contributory schemes have done much already to fill them. The individual is still entitled to benefits, such as help towards the cost of private ward accommodation or the cost of convalescence, and, in most cases, cash payments to help to meet loss of wages and increased costs at home arising from the illness, but this is only a part of what the schemes now provide. Substantial grants have been made to hospitals to provide amenities which cannot be provided from public funds, mobile physiotherapy units have been supplied, and convalescent homes and recuperative homes have been opened and maintained. The contributory schemes have seen that although the Act has removed the need for much that was undertaken by voluntary effort in the past it has opened new paths for the voluntary relief of human suffering.

The contributory schemes provide the means whereby people whose income is small may be encouraged to give small sums in voluntary contributions. There must be many people who would like to give money to help their fellow men in time of need, but who feel that what they could afford to give would be so little that it would not be gladly received. Through the contributory schemes such people can give their few pence each week and by so doing know that if the need arises they will be helped themselves. We feel that in this way the contributory schemes are helping to keep alive the spirit of personal charity in an age in which to give is not always considered better than to receive.

Conclusion

Voluntary service can be seen in action ; its motives cannot easily be analysed and its inspiration cannot be fully defined. We have seen it in action, and we have come to realise how varied and widespread are its activities, how strong are its loyalties, and how immeasurable are its qualities.

We have seen men and women who give their time to committee service, acquiring the technical and local knowledge on which judgment and decision must be based and striving to improve the hospital services with the problem of restricted budgets always confronting them ; we have seen women who work in the hospitals, nursing, sewing, visiting patients, manning trolley-shops and canteens, and women whose voluntary work lies outside the hospital, driving hospital cars, giving help and care to the sick and infirm in their own homes, taking patients for outings ; we have seen men who drive ambulances, stand by in cinemas and at football matches, sing and entertain at hospital concerts, take mental patients and old people to see something of the world outside the hospital. We have seen all these and more, and we have realised that we have seen but a small part of the voluntary service that is given quietly and unobtrusively day by day, week by week, and year by year. Surely this voluntary service is something of which this country should be proud, something that none but a free society could produce. At the end of our survey this is the thought that is uppermost in our minds.

The partnership of the State and voluntary service in the administration of hospitals is, in our view, a courageous and imaginative experiment. We believe that it will succeed if the voluntary partners, the Regional Hospital Boards and Hospital Management Committees, and the Boards of Governors of the teaching hospitals, are given a full share of administrative responsibility and authority and are trusted to exercise "enlightened economy," and if the boards and committees will themselves delegate real responsibility and authority so that the hospitals themselves are not excluded from the administration which affects them so vitally but take their part in it. Above all we believe that voluntary service has something vital to give to the administration of the hospital service, something that administration by the professional, however efficient, can never give.

There is no doubt in our minds that voluntary personal service in the hospital, and to the sick and infirm outside the hospital, must continue and must be expanded. It is essential service both to the hospitals and to the many thousands of people whom it serves. It provides not only efficient and devoted work but something that is individual within a framework that must tend to become standardised. Rightly used it is an asset of immense value, and the mixture of volunteer and professional with a common purpose is one of richness and strength.

That voluntary financial contribution to help the sick and infirm should continue, and should be encouraged, seems to us of great importance. The hospitals will never

cease to be "our hospitals" if those whom they serve can make their gifts, however small, of money and service. Charity cannot be killed ; it lives in humân hearts.

We have seen for ourselves that for voluntary service of all kinds there is more need now than ever before, and we see no likelihood of the need decreasing. As Lord Beveridge has said, "there is a perpetually moving frontier for voluntary action."

These are our general conclusions. It now remains for us to consider what light is thrown on the question which underlies the whole of our work, the relationship of voluntary service and the State.

In our first chapter we made the point that the scope of voluntary service at any one time must depend on the prevailing concept of the rôle of the State. We live in what is often described as a "Welfare State," and its critics commonly claim that the more the State provides for the welfare of its citizens the less opportunity is there for individual initiative and enterprise. This is a fair enough claim, yet throughout our examination of the national hospital service, a service provided by the State, we have seen many examples of individual initiative and enterprise. The conclusion that we draw from this is that what is fundamentally important is not whether a national service is or is not provided by the State, but the way in which it is provided. We believe that if we had been examining a national hospital service that was directed by the central authority and administered by them through a hierarchy of salaried professional staff, and that provided for all services to the sick and infirm, in the hospitals and outside, to be performed by salaried officers, we would have seen a different picture. We believe that the humanity and vitality of the hospital service to-day is due to the decision of Parliament in creating a national service to make full use of voluntary effort. That this was a deliberate choice was shown by an official statement made in the House of Lords on behalf of the Government by Lord Pakenham on the 22nd June, 1949, at the conclusion of a debate on voluntary action for social progress. Lord Pakenham said that he thought it would be the wish of the House that he should give a careful description of the government's attitude to voluntary action. He then continued as follows :

> "We consider that the voluntary spirit is the very life-blood of democracy. We consider that the individual volunteer, the man who is proud to serve the community for nothing, is he whose personal sense of mission inspires and elevates the whole democratic process of official governmental effort. We are convinced that voluntary associations have rendered, are rendering, and must be encouraged to continue to render, great and indispensable service to the community . . . I want to make it plain, beyond any shadow of misunderstanding, that, in the view of the government, democracy without voluntary exertion and voluntary idealism loses its soul."

We believe that we have seen something of the way in which the voluntary worker with a "personal sense of mission inspires and elevates the whole democratic process of official governmental effort," both by serving as a partner in the administration of the hospital service and by giving his services in many different ways for the benefit of his fellow men. Our only concern is lest for administrative convenience and tidiness the official and professional partner should seek to lessen the authority and responsibility of the voluntary partner, and should be so unimaginative as to try to make him work in complete conformity with accepted official practice. By so doing he would destroy his greatest quality.

Surely it is this concept of partnership which is all-important. If the State provided such national services as are needed to guarantee a full measure of "welfare" to all its citizens, and made no call on its citizens to contribute to them other than by compulsory financial levy, it would create a division between the State on the one hand and the people on the other, and between them there would be a "great gulf fixed." How different would this be from what we have said that we hoped would be regarded by future historians as the prevailing concept of the State in our time—"not a deity to be worshipped, not a power to be feared, but the individuals composing it acting collectively for their mutual benefit" ! The danger is that such a division might be created by people acting with the best of intentions.

The alternative is partnership, a partnership in which the State provides and yet calls upon its citizens to play their part to the full. This, we believe, is the way in which freedom can be preserved within an ordered structure under central direction. The great 19th century apostle of freedom, John Stuart Mill, in the final paragraph of his famous essay "On Liberty," published in 1859, summed up the same thought in these words :

> "A government cannot have too much of the kind of activity which does not impede, but aids and stimulates, individual exertion and development. The mischief begins when, instead of calling forth the activity and powers of individuals and bodies, it substitutes its own activity for theirs ; when, instead of informing, advising, and, upon occasion, denouncing, it makes them work in fetters, or bids them stand aside and does their work instead of them. The worth of a State, in the long run, is the worth of the individuals composing it ; and a State which postpones the interests of *their* mental expansions and elevation to a little more of administrative skill, or of that semblance of it which practice gives, in the details of business ; a State which dwarfs its men in order that they may be more docile instruments in its hands even for beneficial purposes—will find that with small men no great thing can be accomplished ; and that the perfection of machinery to which it has sacrificed everything, will in the end avail it nothing, for want of the vital power which, in order that the machine might work more smoothly, it has preferred to banish."

We believe that voluntary service brings out the best qualities in human beings, and if it is true that "the worth of a State, in the long run, is the worth of the individuals composing it" the preservation of voluntary service in society is of the utmost importance. There must be no facade of preservation ; it must be a reality.

What is this "voluntary service" of which we have written so much ? Can we not say that, as we have seen it, voluntary service is man's gift to his fellow men, a gift that each can make whatever his estate ? In its highest form it is the gift of oneself, but not all can reach these heights. "Charity" in "The Pilgrim's Progress" says :

> "I do not mean by charity only that branch of it which bears the fruit of material good works, in feeding the hungry, giving drink to the thirsty, clothing the naked, visiting and redeeming prisoners and captives, harbouring those that want a place to lay their heads in, visiting and relieving, comforting and healing the sick, and the like acts of mercy. Charity is of a larger and more spiritual extent than all these good works amount to ; nay, some of them may be performed without charity."

True voluntary service, as a gift to one's fellows, can be given only by those who have charity in their hearts ; where voluntary service is given without charity something vital is lacking.

We believe then that the "voluntary spirit" that inspires true voluntary service is something that is of the essence of greatness in man, and that a nation that fails to make use of this gift can never be a great nation. Such a nation will never succeed in killing the voluntary spirit in man, a spirit that has endured throughout the ages, but by putting it in chains it will be imprisoning the qualities that it needs most of its people.

APPENDIX I

Summary of answers to questionnaire sent to Secretaries of Regional Hospital Boards, Hospital Management Committees and Boards of Governors of teaching hospitals. Form of analysis used by permission of P.E.P. (Political and Economic Planning).

ANALYSIS OF MEMBERSHIP OF BOARDS AND COMMITTEES

	R.H.B's		*H.M.C's*		*B's of G.*	
	Total	%	*Total*	%	*Total*	%
Age of Members						
30—39	4	1%	58	4%	10	3.5%
40—49	47	15	379	24	69	25
50—59	131	43	604	38	124	45
60 and over	126	41	544	34	73	26.5
Sex						
Men	263	85%	1191	76.5%	323	84%
Women	47	15	394	23.5	63	16
—of whom married	27	57	270	69	45	71
Trade or Profession						
Doctors and Dentists	90	29%	439	26.5%	127	33%
Other Professions	63	23	166	9	77	20
Industrial Executives	14	4	83	5	18	5
Commerce and Distribution (Owners and Managers)	29	9	205	12.5	37	10
Clerical and other non-manual workers	28	9	121	8	24	6
Manual Workers	9	3	89	6	9	2
Retired or Independent (men)	50	16	268	16	46	12
Housewives	24	7	279	17	47	12
Membership of other Bodies						
Local Government	119	38.5%	539	32.25%	69	18%
Executive Council	27	8.75	213	12.75	24	6
R.H.B., H.M.C.	188	60.75	209	12.5	89	23
House Committee	*	*	896	53.5	77	20
Number with previous experience of hospital work	263	85%	1276	76%	263	68%

Returns received from 12 of the 14 Regional Hospital Boards, 94 of the 378 Hospital Management Committees, and 14 of the 36 Boards of Governors of teaching hospitals.

* *Insufficient information.*

APPENDIX II

NOTES ON THE ELEVENTH REPORT OF THE SELECT COMMITTEE ON ESTIMATES

The Select Committee on Estimates in its Eleventh Report to Parliament, which was published in September, 1951, after Chapter IV had been written, included important statements, and recommendations relating to matters dealt with in this report, as follows :

The Structure of the Service (*see page* 48)

"Whatever may have been the original intention regarding the respective functions of the Minister, the Regional Hospital Boards and the Hospital Management Committees, it became clear to your Committee that there have been substantial changes in this connection, that a great deal of doubt and difficulty still exists, and that the satisfactory progress of the Service depends on a solution of the problems involved."

Financial Control (*see page* 49)

"A second example of how the position of the Regional Hospital Boards has deteriorated, in the matter of financial control, dates from the 31st March, 1951. Until then, Regional Hospital Boards had the power to allow Hospital Management Committees to transfer their expenditure from one sub-head to another. This power was withdrawn with effect from that date and reserved to the Ministry of Health. Regional Hospital Boards protested strongly when this was done, and, for the financial year 1951-52, the Ministry have proposed an uneasy compromise under which they and the Regional Hospital Boards are both to have power to authorise Hospital Management Committees to transfer expenditure from one sub-head to another."

Tendency towards centralisation (*see page* 47)

"The development of the Hospital Service appears to have reached the parting of the ways ; either the Ministry must decide to give greater scope to the Regional Hospital Boards than they at present enjoy, or alternatively they must move towards reorganising the service on the basis that the functions of the Regional Hospital Boards are purely of a planning and advisory nature. The choice between these alternative aims is a major question of policy on which your Committee cannot make a recommendation. Nevertheless, they have formed the opinion that if the decision is not taken to enlarge the powers and to increase the independence of the Regional Hospital Boards, better results would be achieved and better relations established in the Service if the Ministry were to deal direct with Hospital Management Committees in financial matters through their Principal Regional Officers instead of through Regional Hospital Boards."

Block Grants : Transfer and Carry-over of Unspent Balances (*see page* 57)

"One solution to the problems caused by the present system of estimating was proposed by nearly all the witnesses examined. It was usually described as a system of block grants. The witnesses appeared to have in mind, in fact, what are known in parliamentary language as "grants in aid.' By this, the supporters of the proposal meant that, as far as possible, the money allocated to hospitals should be in lump sums not tied to particular sub-heads or expendable in any specified period. It was generally agreed that the preparation of estimates would still be necessary, though these could be greatly simplified. It is to be observed in this connection that the Nuffield Provincial Hospitals Trust and the King Edward's Hospital Fund for London, who are investigating the preparation of cost accounts in hospitals, considered that statistics of costing would be of great assistance in deciding how much money should be allocated to each hospital if some block grant system were introduced.

"It was suggested that the Ministry of Health, in giving their approval to these simplified estimates, should not approve each sub-head individually, as at present, but should issue a lump sum to each Regional Hospital Board and leave it to the Board to distribute the sum among their Hospital Management Committees. The Hospital Management Committees would, in their turn, be free to use the money in the way they thought most appropriate ; any unspent balance at the end of the year would accrue to the hospital making the saving and would not be returnable to the Exchequer.

"Much evidence was given to Your Committee by Regional Hospital Boards and Hospital Management Committees tending to show that the strict limitation of expenditure to the sub-heads of estimates approved by the Ministry was a deterrent to economy. A saving made under one sub-head may not now be transferred to another sub-head without the Ministry's consent and since at the end of every financial year the authority to spend any unspent money lapses, the hospital authorities are tempted to make their estimates for every sub-head as large as possible and then to spend all the money allocated to them on what they can within that sub-head.

"Coupled with the request to be allowed to transfer between sub-heads was the request to be allowed to carry over unexpended balances. It was urged that hospitals would be more economical if they knew that any saving they might make on their estimates would not be lost at the end of the year. The Ministry of Health have resisted this proposal on the ground that such a system is quite contrary to established principles regarding voted moneys other than grants in aid. In the event, however, of the introduction of a system of grants in aid or 'block grants,' as described in paragraph 15, the authorities receiving such grants would automatically possess powers of transfer and carry-over. Possession of these powers appeared to be one of the main objects of the advocates of block grants. For a block grant system to be effective, however, it is necessary for the grant to be made either of a fixed amount or at least in accordance with a definite formula for a series of years such as five or, at the least, three. Otherwise, annual detailed estimates would still be needed to fix the varying annual grant and hospital authorities would be in no better position with regard to their unspent balances at the end of each financial year than they are at present.

"The Ministry of Health were asked if they were, in fact, contemplating the introduction of a system of block grants. In reply to the question, 'You are moving in the direction of allocating a total pre-determined sum to the hospitals and dividing that sum between the Regions in accordance, if not with a formula, at any rate with a pre-determined policy ? ' the witness replied 'Yes.' He stated, moreover, that the Ministry intended to leave the sub-allocation of each Region's share between Hospital Management Committees very largely to the Regional Hospital Board. Their further intention was, however, to retain the final decision over this sub-allocation, and Regional Hospital Boards would have to submit their proposals for sub-allocation to the Ministry.

"The working out of a satisfactory system in this novel field of administration must be largely empirical. It must also be gradual, in that much essential spade-work, such as the preparation of a sound cost accounting system for hospitals, in England and Wales, still remains to be done. Moreover, the Service is not as yet sufficiently stabilised for hospital authorities to be able to estimate their needs several years in advance, so that a grant for three or five years might be practicable.

"Nevertheless, Your Committee are of opinion that something more than a slight modification of the system hitherto in operation is necessary. The aim, in their view, should be the largest possible degree of decentralisation, to be effected as soon as it can be carried out. It may be noted in this connection that the Ministry of Health witness stated that he had no reason to believe that if Parliament were to give a grant in aid there would be any difficulty or wastefulness, and that he saw no difficulty in operating a system of grants in aid of the magnitude proposed. It should be added, though, that he had no confidence that Parliament would follow such a course."

Whitley Councils (*see page* 66)

"Your Committee recommend that the Departments concerned should give urgent consideration to the whole application of the Whitley Council system to the Hospital Service."

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