# Chapter 5

# Public, private and voluntary hospitals: economic theory and historical experience in Britain, c.1800-2010

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## Introduction

In considering the balance of public and private in the history of the British hospital, we may helpfully think in three, rather than just two categories: public, private and 'voluntary'. We may also distinguish different periods, particularly across the juncture of 1948, when the establishment of the National Health Service (NHS) disrupted existing patterns of ownership and financing and heralded a period of active management by the central state. Crudely we can classify the public hospitals as those funded principally by taxation and overseen by some appointed or elected body subject to statutory regulation. The private hospitals we may consider as those run for profit and privately owned. The voluntary hospitals we may understand as those financed principally by philanthropy or mutual funds, staffed largely by honorary consultants, constituted as charitable trusts and managed by volunteer committees. In the British narrative, the for-profit hospitals do not figure significantly, though there were numerous nursing and maternity homes, commercial 'lunatic asylums' and private beds or wings within

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voluntary hospitals; private hospitals remained of limited scale under the NHS. Thus, the dynamic of most interest is that between the voluntary and public sectors before 1948, and within the public sector afterwards.

The British hospital has an established narrative of change, broadly understood as a social response to industrialisation.[1] The public hospital emerged from the Poor Law workhouse and was systematically developed in the Victorian period. Psychiatric hospitals—'asylums'—were predominantly provided by county or municipal councils and from the 1870s local government also oversaw isolation hospitals for infectious diseases. Voluntary hospitals emerged in the eighteenth century, then proliferated, generally prioritising acute but non-infectious diseases, and leaving long-stay, 'chronic' and psychiatric patients to the public sector. This changed in the twentieth century as municipal hospitals and public infirmaries expanded general care. A radical break occurred in 1948, when the NHS Acts took the voluntary hospitals into public ownership, also incorporating local government hospitals, public asylums and many ex-Poor Law institutions. NHS history breaks into an early statist period marked by central planning, albeit ineffective, then from the 1980s an effort to introduce market disciplines under the aegis of 'neo-liberalism'. There was also a trend of dehospitalisation, as technological and surgical processes allowed for shorter stays and community treatment.

The aim of this chapter is to explain the changing relationship between public, private and voluntary sectors over this long period. As a framing device, it will use a body of theory drawn principally from welfare economics, which makes normative claims about the strengths and weaknesses of each sector. After introducing these ideas, the discussion that follows asks how adequately they address four questions that are not usually confronted explicitly:

1. How to explain the growth of the hospital since the eighteenth century, and the distribution of activity between private, public and voluntary sectors?
2. How to explain the transfer of control from the voluntary sector and local government to the central state in the NHS system reform of 1946-8?
3. How to explain the pattern of decline of the hospital in the later twentieth century, and the distribution of activity between the public and private sectors?
4. How to explain and appraise the market-oriented management reforms adopted in the NHS since the 1980s?

The analysis synthesises existing work based on what is already a rich literature, combining policy history with a strong quantitative underpinning.

## Market, voluntary and state failure

A preliminary conceptual framework to aid thinking about the sectoral dynamics of the British hospital is presented in Figure 5.1. This proposes various positive 'virtues' of the market, voluntary institutions, and the state as providers of health care, and also various inherent 'failures' that may explain why each predominates at different times. As outlined below, it is constructed from the longstanding literature of welfare economists, and more recently from the fields of health economics and third sector analysis.


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***Figure 5.1: A conceptual model of hospital sectors in time***

| | Market | Voluntary | State |
|---|---|---|---|
| Virtues | Price mechanism; responsive to demand; quality. | Mobilises supply; resolves trust failures; innovation; advocacy. | Sufficiency of supply; resolves trust failures; integrated planning. |
| Failures | Free riders; information asymmetries; trust failures; insufficiency for catastrophic costs | Free riders; insufficiency; unevenness; paternalism; uncoordinated; amateurism. | Bureaucratic maximising; rent-seeking, 'provider capture'; no voice or exit. |
| | | | |
| Change | Transition from voluntary/local/private towards public. | | |
| Change | 'objective reasons of a stringent nature'; 'majority opinion'; changing 'social ideas'; 'displacement effects' of war. | | |

It is axiomatic to classical economic theory that free markets can most directly satisfy human needs. Competition drives innovation and quality, the price mechanism optimises the balance between supply and demand, and an 'invisible hand' ensures that by meeting individual utility markets will increase the general welfare.[2] However, theory had also to contend with the growth of public expenditure. Adolph Wagner's 'law', propounded in Bismarckian Germany, first claimed this as an inexorable concomitant of economic growth.[3] Later there developed the concept of public goods, whose benefits ('positive externalities') extended to all, not just their immediate purchasers—urban sanitation systems that reduce infectious disease, for example. To avert 'free riding' by other beneficiaries, collective intervention could be justified. Another market failure could arise from imperfect information, where the purchaser lacked the requisite knowledge to assess the price of a technically complex service, such as medicine. This introduced a 'trust failure', where sellers might be tempted to profiteer, particularly if,

as in the case of doctors, they exercised a professional monopoly. It was also arguable that health care was not really a consumer good at all, because the catastrophic expense of serious illness might price supply beyond the means of average earners.[4]

What about voluntarism? An economic 'language of sectors' emerged in the mid-twentieth century, making general claims about the capabilities and limits of charity, as it reoriented under the welfare state.[5] This asserted the voluntary sector's role was to pioneer new forms of intervention, reach hitherto neglected groups, produce individualised services, and advocate for change. In this sense, it could address insufficiencies of supply when catastrophic costs threatened and, because it was premised on philanthropic ethics, could resolve trust failures. It was also unfettered by the bureaucracy or need for consent that accompanied state action.[6] However, voluntary failures were also observed. The problem remained of free riders enjoying the positive externalities funded by charitable citizens alone, not least in public health.[7] Other weaknesses were a lack of co-ordinating mechanisms, undemocratic governance, under-resourcing, amateurism of the workforce and political ineffectiveness. Third sector theorists subsequently augmented this catalogue. Philanthropy was inherently insufficient and geographically uneven, because its spontaneous nature, its reliance on wealthy givers, and its lack of coordinating mechanisms meant that supply could not match demand. Charity's paternalist and hierarchical overtones also offended equity considerations.[8]

These failures opened the way for the state. Whether through mandatory insurance or social security, public funding ensured sufficiency of supply while averting free riding in the provision of public goods. Planned distribution could overcome geographical or social unevenness, and bureaucrats appointed on merit could deliver professional administration. Trust failures from information asymmetries could be overcome through expert oversight of pricing, and sanctions. Yet

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against these virtues, the lineaments of state failure were soon set out, both by Hayekian neo-liberals and by rational choice theorists. Because bureaucrats seek to maximise their own utility rather than pursuing the public interest, they will try always to enlarge departmental budgets to obtain status and power.[9] Nor does the state necessarily prevent rent-seeking by professionals.[10] Instead there is a tendency to 'provider capture' by public employees—doctors, nurses, administrators—who organise services to suit their own preferences, not the consumers'.[11] The patient meanwhile lacked the levers of 'voice and exit', which in market settings would permit the expression of demand.[12]

So much for theory—what about application to historical examples? To the extent they exist, these addressed the supersession of voluntary, local or market approaches by the central state.Wagner had attributed his 'law' to technological costs, the desire for education and culture, and the social frictions arising from urbanisation. Polanyi argued that the 'practical and pragmatic' advance of social legislation responded to the 'objective' needs of industrial societies to manage the 'weaknesses … inherent in a self-regulating market', a functionalist 'countermove' against 'degradation'.[13] Peacock and Wiseman's long-run study of British public expenditure observed this rising at a far greater rate than GDP, indicating a 'natural ... propensity' of democratic citizens to consume desirable services, compounded by the 'displacement effects' of war, which legitimised state action.[14] New right readings interpreted the same processes first as vote-seeking by cavalier politicians, and later as the errors of socialism, which overturned the successes of capitalist welfare.[15]

The following discussion asks how well this welfare economics model of sectors explains historical transformation in the hospital. Its appropriateness need not be presumed *prima facie*, for its different components were designed to illuminate the present, not to explain change. Despite the accoutrements of social science, such theory was

usually developed from assumptions about behaviour rather than empirical testing. Where causation was identified, it was generally in very unspecific terms, evoking broad shifts of majority opinion in liberal democracies. Nonetheless, in what follows it provides a useful heuristic to begin thinking about the problems of growth, change and decline within the three hospital sectors.

## Before 1948: patterns of growth and sectoral distribution

The first point to make is that markets do not appear to have prevailed in early hospital provision. In the modern period, the private hospital was most obviously discernible in the area of psychiatric care. By about 1800 surveys of the institutional distribution of 'lunatic' patients showed approximately 200 in private 'madhouses', with some 600 in charitable asylums (the York 'Retreat' for Quakers is the best known), and uncertain numbers in the parish or union workhouses and gaols.[16] It seems plausible that small-scale market operators met demand from families unable to manage insane kin, although many inmates were in fact admitted under contract from Poor Law authorities.[17] The main trend through the nineteenth and early twentieth centuries was the massive expansion of the public sector, following legislation in 1808 to establish rate-funded county asylums. Thenceforth there was a very large rise in the numbers of 'lunatic' admissions—from 477 in 1819-20, to 7,144 in 1850, to 74,004 in 1900—though part of this represented transfers from existing Poor Law accommodation.[18] Private patients were subsequently only a small proportion of the whole: nineteen per cent in 1844, to eleven per cent in 1870 and nine per cent in 1890.[19]

The other manifestation of the public hospital was the infirmary function of the Poor Law workhouse. Parish Poor Law accommodation


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dates back to the Elizabethan origins of statutorily enshrined localist poor relief. The power to incorporate several parishes to provide a large institution from a broader resource base was originally limited to act of Parliament and thus confined to London and major cities—about fifteen had done so by 1712.[20] Sporadic surveys suggest 129 workhouses were open by 1725, 700 by 1732 and by the 1770s there were some 2,000 institutions, with about 90,000 places.[21] Gilbert's Act of 1782 permitted autonomous combinations of parishes into unions, encouraging more construction. Workhouses accommodated a mix of inmates including the insane, sufferers of infectious diseases, infirm older people, orphaned children, homeless or tramping workers, stigmatised single mothers and the destitute. The mid-nineteenth century saw systematisation through the Poor Law Amendment Act (1834), which created larger administrative 'Unions' and a network of institutions financed by local taxes. The pattern of the mid-century was initially for approvals of general workhouse building with standardised designs, and subsequently for more specialised units, particularly sick wards, within building complexes.[22] Thus, by the early 1900s some workhouses in larger cities had developed as public infirmaries, while others had separate infirmary blocks.

Meanwhile, from the 1870s a network of infectious diseases hospitals emerged, also funded through local property taxes and managed by borough and district councils.[23] These provided isolation facilities for those with notifiable infectious diseases, such as smallpox, scarlet fever, typhoid and diphtheria. In 1929 a Local Government Act carried forward the development of public general hospitals by 'breaking-up' the Poor Law and transferring its functions to local councils, who could then remove the infirmaries from the stigmas of poor relief and manage them as municipal institutions, from which citizens would not be deterred. By 1938, as Table 5.1 shows for England, the public infirmaries—general, poor law or isolation—remained the most important provider in respect of medical care, and also dominated the psychiatric field.

***Table 5.1: Numbers and Percentage Distribution of Hospital Beds by Type (excluding asylums) 1861-1938***

| | 1861 | 1891 | 1911 | 1921 | 1938 |
|---|---|---|---|---|---|
| Voluntary | 14,772 | 29,520 | 43,221 | 56,550 | 87,235 |
| Public | 50,000 | 83,230 | 154,273 | 172,006 | 175,868 |
| Private | | 9,500 | 13,000 | 26,166 | 22,547 |
| | | | | | |
| | % | % | % | % | % |
| Voluntary | 18.51 | 26.2 | 21.89 | 24.75 | 33.14 |
| Poor Law | 81.47 | 64.71 | 61.31 | 52.64 | 19.94 |
| Local Government | | 9.16 | 16.76 | 22.63 | 46.89 |

Source: Robert Pinker, English Hospital Statistics, 61-2; B.Abel-Smith, The Hospitals, 1800-1948, 189

As for the voluntary hospitals, an early wave of foundations in the capitals and provincial cities occurred in the eighteenth century, bringing about sixty general and special hospitals into existence.[24] The endowed trust was superseded as main philanthropic vehicle by this new style subscriber charity, in which donors were issued with admission tickets that they could dispense to applicants (with emergency patients admitted automatically).[25] After 1800 general hospitals opened in most large towns, while specialist institutions (maternity, ophthalmic, ear, nose and throat etc.) followed. Finally, in the late nineteenth and early twentieth century a cottage hospital movement promoted smaller rural institutions.[26] Medical education was supplied at the largest voluntary hospitals, first by honorary consultants providing clinical teaching for apprentices and subsequently through formal links with medical schools.[27] By the early twentieth century, the transition of voluntary hospitals from primarily philanthropic to primarily medical institutions was complete, with the


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teaching hospitals now major centres of research, laboratory-based diagnosis, clinical training and care.[28]

What about private care? Pay-beds or wards for general medicine were also located in voluntary hospitals, in small numbers, and by the 1930s some had built private blocks as money-making concerns. In London, where these were most numerous, there were 552 paying beds for middle-class patients in 1921, rising to 2,260 by 1938, nearly 11% of the total.[29] This reflected the presence of technical services like radiotherapy and orthopaedic surgery, which removed the social stigma of entering a hospital. By the 1920s there were also considerable numbers of small nursing and maternity homes, with about 26,000 beds.[30] Some were managed by qualified nurses, where eminent doctors attended wealthy patients. Others, prior to licensing legislation (1927), were run by unqualified people, and included centres of complementary healing, rest cures, and 'massage houses'.[31] There was also a trend towards means-tested user fees in the interwar voluntaries, to compensate for the diminution of philanthropic largesse that followed rising tax burdens. However, this was quickly offset by the expansion of mass contributory schemes based principally on small payroll deductions. Given the small scale of the for-profit sector, a private medical insurance system was slow to develop.[32]

How does this first phase fit the specifications of welfare economics for state and voluntarism as reaction for market failure? There seems no evidence that the modern hospital sprang from an inadequate private sector. Nor had that been true of the early or pre-modern hospital. As Guenther Risse's *longue durée* global survey suggests, the hospital has since early times been a 'house of ritual', with its disciplines, daily routines, uniformed staff and ward organisation.[33] Over the very long run, an interplay between religion and the state seems to have been the driver, whether in the sacred settings of Ancient Greek Asclepeiae, or Roman legionary hospitals, or monastic infirmaries, or medieval

leper houses, or in the 'hospitals' for orphaned children. An ethic of 'caritas' on the one hand, and on the other the expression of collective purpose by ruling elites, have always mattered most, not the imperative of commerce.

It could however be argued that the new public hospitals responded to a different kind of market failure under early capitalism. Foucault's concept of a 'great confinement' discernible across Europe puts it in simple terms. New spaces of constraint were created by governments—France's *hôpital general*, Britain's workhouse, the German *Zuchthaus*—to house populations defined by their place outside the labour force, including the mad, the sick, the 'beggar', the 'vagabond' and the 'moral libertine'.[34] For Foucault, this was the assertion of 'bourgeois order' through the local arms of the state.[35] The British workhouses, in which public hospital care became embedded, restricted mobility by localising entitlement. Eligibility was also anchored to the complementary 'out-relief' system, providing doles to manage labour market seasonality. More than this though, they represented the liberal creed that poverty amongst working-age adults was moral failing, legitimising crusades against out-relief after 1834 and again in the 1870s.[36] The gradual distinction between the hospital and workhouse function was therefore in part a recognition that sickness caused poverty regardless of character—the germ of the catastrophic costs insight—and so justifiable as both humanity and efficiency.[37] Yet the underlying rationale of separating categories of pauper into deserving and undeserving of aid also meant that as medicalisation proceeded standards tended to be low, with the work disdained by doctors. [38]

The rise of the county asylums also testifies to the default role of the state, rather than the market or charity, in segregating and managing populations unable to negotiate the transition to modernity. Alongside traditional physical restraint, the public asylum adopted new therapeutic routines, which sought to manage insanity in an environment of work, morality and order that instilled social norms and self-control.[39]


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Scholarship typically treats the expanding populations of county asylums as a response to rapid urbanisation, which disrupted the solidarities of kinship and community through which emotional distress and psychiatric illness had formerly been dealt.[40] Thus, as fast as the state provided accommodation, so isolated individuals or the families of the insane increased their utilisation—an early manifestation of 'Roemer's Law', that demand for health services tends to follow supply.[41]

What explains the emergence of the British voluntary hospital? In the European context, this was unusual, as elsewhere a single hospital sector that blended philanthropy and public financing was more typical. In part, the voluntary hospital was the obverse of the Poor Law, similarly founded on assessment of entitlement. Its patients were those who merited benevolent support rather than state assistance premised on dependency; here was more forthright acknowledgement that unpredictable and potentially catastrophic illness could impoverish prudent wage-earners. This judgment manifested in the inpatient admission system revolved around obtaining a subscriber's letter from a local dignitary or businessperson. In practice the 'deserving/undeserving' binary was muddy, with quite similar patient populations and voluntary admissions favouring recent in-migrants without a Poor Law settlement or kinship support. Voluntary provision was therefore also a way of managing the labour mobility necessary for economic growth, by prioritising adults of working age with maladies susceptible to cure. [42] The ubiquity of major local employers as donors or subscribers (increasingly through firms rather than as individuals) ought not to be read as kindness alone.[43]

However, it would be reductionist to attribute the voluntary hospital entirely to concerns for human capital and social order. Part of the explanation lies with the supply side: the charitable resources generated by the peculiar combination of factors that underlay British economic dynamism—high agricultural productivity, colonial 'ghost acres' powering trade, finance and services, and the classic industrial revolution

in textiles, metals and cheap energy. Also important was the social and political appeal of voluntary association to the urban middle classes.[44] This provided the basis of a new public sphere that undergirded networks of trust, sociability and civic action for both men and women. The personalised admission ticket system also tightened bonds of obligation within hierarchical societies, in ways that the depersonalising Poor Law did not. Finally, because the voluntary hospitals largely accommodated 'deserving' patients with acute diseases, honorary consultants could work in them without loss of social status. Hence it was here that biomedicine became grounded once the Paris revolution in clinical practice diffused outwards, and a more thoroughgoing medicalisation took place.

## 1942-8 Explaining the critical juncture

For the hospital, the mid-twentieth century establishment of the British NHS marked a distinct break in several respects. The broad parameters of the 1946-7 legislation ensured universal population coverage, comprehensive service provision meeting needs 'from cradle to grave', and progressive tax-funding which rendered access free at the point of use. [45] Within this settlement, voluntary hospitals were 'transferred' from their 'governing body or trustees' and 'vested' in the Minister of Health.[46] Effectively this was compulsion, though hospitals could apply to be 'disclaimed'; 230 were so treated, mostly small religious institutions, hospices and convalescent homes.[47] They now came under the control of appointed statutory bodies, which also oversaw the former Poor Law and local government hospitals. Existing charitable endowments were taken over by the state, although the teaching hospitals retained theirs, with the restriction that they could only be spent on 'non-core NHS' areas: amenities for patients and staff, medical research,

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and building improvements. Financing came from general taxation, supplemented by a small proportion from national insurance. This built on a growing consensus about the justice of basing state revenue on high levels of income tax, both as a response to the Depression, then to finance the war effort.[48] Along with the demise of locally raised funding went grassroots democracy, hitherto exercised through the local ballot box or on voluntary hospital management committees (which by the 1930s, combined patrician, bourgeois and worker governors).[49] Instead control now resided with the central state, through the accountability of the Minister of Health to Parliament. Private beds were permitted to continue, as a necessary compromise to win professional consent for the reform, but hospital consultants (though not GPs) now became salaried staff.

The short-term narrative of change runs as follows. In the late 1930s a momentum grew amongst health bureaucrats, 'think-tanks', progressive doctors and leftist social reformers in favour of health system reform, with ministerial discussions sparked by funding difficulties in the London teaching hospitals. During wartime, the policy process quickened pace, in response to 'Assumption B' of the Beveridge Report, which stated the necessity of a comprehensive health service within a universalist welfare state. The coalition government introduced proposals for this, including reform of voluntary hospital funding, sidelining charity and mutualism in favour of taxation, and this in turn sharpened debate about how public accountability would follow. The interest groups (doctors, hospital leaders, contributory schemes, local government) disagreed on the optimal arrangements and deadlock ensued. Labour's sweeping victory in 1945 gave Bevan a free hand to override these interests with his bold solution, for in reality only the doctors wielded any political leverage. The BMA was duly pacified with the concession on private beds, and by generous remuneration: GPs remained mostly private contractors to the service, while hospi-

tal consultants became salaried. On 5 July 1948, the 'appointed day', the NHS was launched.

Does the welfare economics model, which foregrounds voluntary failure and shifting 'majority opinion', provide an adequate explanation for the hospital settlement? There is good evidence that spatial distribution of voluntary hospital beds was highly uneven, and often inequitable. The 'caprice of charity', in Aneurin Bevan's words, favoured London and wealthy towns like Bath and Oxford, while manifesting an 'inverse care law' of under-resourcing in poor areas like South Wales.[50] However, the pattern of municipal hospital provision was increasingly plugging these gaps, and in this sense a public/voluntary mix still remained viable.[51] Charitable insufficiency also challenged some hospitals. Current account deficits and erosion of capital reserves worsened during the 1930s, as expenditure on staffing, equipment and supplies soared. In part this reflected the inability of middle-class philanthropy to keep pace with patient needs, and although the voluntary sector also generated the solution of mass contributory schemes, these further fueled demand.[52] Again though, financial shortages were limited to particular areas and types of hospital (such as teaching hospitals in London and the North West) and there were also locations where the charity of major donors and community activists remained robust.[53] Bevan also made clear he found voluntary paternalism 'repugnant', and there is some evidence of class resentment at hospital patronage in Mass Observation surveys and diaries.[54] Finally, voluntary particularism was also critiqued in a policy discourse replete with tropes like 'co-ordination', 'integration' and 'co-operation' that highlighted the disjointed nature of the existing provision. Though yoked to greater state agency, this was, paradoxically, a language of the market, derived from industrial management where the vertical integration of the firm similarly promised systematic planning and cost saving.[55]


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Beyond this, the case for a shifting social climate in favour of a centralised single-payer system is implicit, not overt. The marked transition of voluntary funding from benevolence to mass contribution (albeit with some charitable overtones) could be read as signalling public acceptance of collective funding, rather than enduring commitment to voluntarism. This was certainly the interpretation of Ministry of Health civil servants.[56] Also heralding change was the demise of the Poor Law, now incorporated within local government, and renamed 'public assistance' to destigmatise access. The idea that consuming public services was a right of citizenship became accepted, and a broad consensus was established around the existing tax and social insurance structure that maintained it.[57] That said though, there is no evidence in contemporary opinion poll data of thirst for reform. On the contrary, most were satisfied with the existing mixed economy, and this only changed somewhat in 1942-5 after the Beveridge Report was disseminated.[58]

In sum, while the welfare economics model provides context for the NHS system change, its evidence is too ambiguous to offer a fundamental explanation. Other causes were contingent, such as the effect of the Second World War, ratcheting the pace of state action through the creation of an Emergency Medical Service. This empowered government to manage the whole hospital sector to cope with civilian and military war casualties, stabilising hospital finances, rationalising labour flows, and accustoming the population to public control.[59] Another relevant consideration is the role of the labour movement. The comparative historiography, pointing for example to the Scandinavian and New Zealand experience, argues that in periods of social democratic party-political control, welfare policy will be more generous and expansive.[60] To the extent that the NHS was the creation of a majority Labour government, and Bevan himself a left-wing tribune schooled in the coalminers' union, this has some salience. But again, it is an incomplete account. Much of the reform process had occurred earlier, under the cross-party wartime coalition government.

Moreover, while some socialists and trade unionists clearly advocated public provision, Britain's labour movement had no unitary position.[61] Many trade unionists were also voluntary hospital worker governors, content with the status quo; others favoured extending coverage through social insurance, not taxation; and the left generally envisaged a local government health service, not one under the central state.[62]

A final aspect of this complex web of causes is the 'institutionalist' analysis, which argues that the nature of the state and the legislative process is the key determinant.[63] The British state had several features that facilitated radical change. It was essentially a two-party system, where elections periodically delivered the winner a strong governing majority, where legislative proposals came predominantly from Cabinet, where members' loyalty to the party whip was the norm, and where law making was unhampered by an obstructive second chamber or a complex committee system. Also in play were path-dependent processes—in the sense of former policy decisions that shaped later trajectories. In particular, the early introduction of national health insurance (NHI) in 1911 had accustomed much of the population to state entitlements, while raising expectations for their expansion (not least to include hospital coverage).[64] NHI had also undermined the opposition of the British Medical Association. Formed in 1832, since the 1890s this had functioned increasingly as the doctor's trade union, initially defending their interests as friendly society employees.[65] Though vocally opposing the NHS proposals, its membership proved more amenable, having experienced the personal economic advantages of state provision since 1911. Probably ministers also concluded that apparently implacable hostility was just sabre-rattling.

A narrow welfare economics explanation therefore furnishes only part of the context for the coming of Britain's NHS, and the consequent impact on hospitals. Other contributing factors were the impact of war, the position of labour and the conducive institutional setting, and last but not least, the electoral mathematics favouring the Atlee government.[66]


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## 1948-2010 The changing pattern of hospital provision and utilisation

In the NHS era, the pattern of sectoral distribution had changed, such that hospitals were now predominantly public institutions. Initially only limited private provision remained under the new dispensation, although, as Table 5.2 illustrates, it was soon to grow.

***Table 5.2: Private Medicine under the NHS, UK 1955-2009***

| | Private Medical Insurance | | Independent Acute Hospitals | | |
|---|---|---|---|---|---|
| | Subscribers | Population | | | Private spend |
| | 000s | Coverage % | Hospitals | Beds | as % UK total |
| | | | | | |
| 1955 | 274 | 1.2 | | | |
| 1960 | 467 | 1.9 | | | |
| 1965 | 680 | 2.7 | | | |
| 1970 | 930 | 3.6 | | | |
| 1975 | 1,087 | 4.1 | | | |
| 1980 | 1,647 | 6.4 | 154 | 7,035 | |
| 1985 | 2,380 | 8.9 | 200 | 9,955 | 9.9 |
| 1990 | 3,300 | 11.7 | 211 | 10,739 | 15.9 |
| 1995 | 3,430 | 11.4 | 227 | 11,681 | 19.8 |
| 2000 | 3,664 | 11.7 | 225 | 9,980 | 19 |
| 2005 | 3,511 | 106 | 213 | 9,578 | 16.4 |
| 2009 | 3,3,425 | 9.7 | 213 | 9,366 | 15.8 |

Source: Laing's Healthcare Market Review 2010-2011, 36, 58, 144

It had survived a fierce debate when the Labour government (1974-9) sought to phase out pay beds in NHS hospitals. Not only did this boost separate private hospital foundations, it also failed in its own terms, with NHS pay beds first falling from 4,919 (1974) to 2,819 (1981), then rising to 3,144 by 1983, following legislation reinstituting NHS consultants' rights to private practice.[67] Private hospital expansion of capacity also followed the fostering of commercial medical insurance by government from the 1980s. Insurance companies such as BUPA and Medicash were descendants of the contributory scheme movement, initially retaining a non-profit stance and socially responsible ethics.[68] Another pre-war philanthropic foundation, the Nuffield Trust, became a significant hospital provider outside the NHS. Other private insurers and hospitals were more purely commercial, and their presence in the British medical market was aided in the 1990s and 2000s by the liberalisation of international trade in services, promoted by the European Union and the World Trade Organisation.[69] More recently, a policy of encouraging NHS commissioners to consider 'any qualified provider' when tendering for services opened further opportunities for sectoral growth.

The other main pattern of change, shown in Table 5.3, lay within the public sector. This was the relative decline of the hospital as a locus of health care, in favour of primary and community settings. The downward trend of utilisation, and the accompanying reduction in bed numbers was visible first and most markedly in the psychiatric hospitals. Here volumes began a sequential decline from the 1950s, which continued in the 1960s, after the then Minister of Health, Enoch Powell, inaugurated a closure policy. A famous speech conjured grim imagery of the asylum: 'isolated, majestic, imperious, brooded over by the gigantic water-tower ... rising unmistakable and daunting out of the countryside'.[70] Part of the aim was to incorporate psychiatric units in new general hospitals proposed by the 1962 Hospital Plan,


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## *Table 5.3: NHS hospital beds and inpatients, 1951—2009/10*

| | All | | | | Mental Health | |
|---|---|---|---|---|---|---|
| | Beds | Beds | Beds | Beds | Inpatients | Beds |
| | Eng & Wa | UK | Eng & Wa | UK | Eng & Wa | Eng |
| | '000s | '000s | Per 1,000 population | | '000s | '000s |
| | | | | | | |
| 1951 | 467 | 543 | 10.7 | 10.8 | 145* | |
| 1955 | 482 | 561 | 10.8 | 11 | 151** | |
| 1960 | 479 | 560 | 10.5 | 10.7 | 135*** | |
| 1965 | 470 | 551 | 9.9 | 10.1 | 124 | |
| 1970 | 456 | 536 | 9.3 | 9.6 | 103 | |
| 1975 | 419 | 497 | 8.5 | 8.8 | | |
| 1980 | 383 | 458 | 7.7 | 8.1 | | |
| 1985 | 348 | 422 | 7 | 7.5 | | 67 |
| 1990/1 | 274 | 338 | 5.4 | 5.9 | | 55 |
| 1995/6 | 222 | 273 | 4.3 | 4.7 | | 39 |
| 2000/01 | 201 | 242 | 3.8 | 4.1 | | 34 |
| 2005/06 | 189 | 226 | 3.5 | 3.7 | | 30 |
| 2010/11 | 155 | 186 | 2.8 | 3 | | 23 |

Source: E. Hawe and L. Cockcroft, OHE Guide to UK Health and Health Care Statistics, London: Office of Health Economics, 2013, 102; Kathleen Jones, History of the Mental Health Services, 358-9; Ewbank, Thompson, McKenna, NHS Hospital Bed Numbers, Figure 4. *1949 **1954 ***1961

further medicalising a field that had hitherto blended treatment with control. Partly it was to devolve greater duties of care to local authority welfare departments, increasingly staffed by professional social workers. This policy accelerated in the 1980s when it was framed as a transition to 'care in the community'.[71]

Also underlying the numerical decline of the public hospital were changes to general health care. The post-war development of geriatric medicine as a specialty had reduced hospitalisation of the older infirm. These were patients who had hitherto been abandoned to the 'therapeutic nihilism' of the residential or infirmary wards of Poor Law institutions, where low staffing and skill levels militated against active treatment.[72] Now bed throughput levels rose, and length of stay declined, again benefitting from the extension of community services such as home helps, home nursing and 'meals-on-wheels' (originally a wartime innovation). Over time the material fabric of the Poor Law legacy was replaced by new hospitals and old peoples' homes (though many sturdy ex-workhouses and asylums enjoy postmodern afterlife as residential housing or business centres).[73] Technological and surgical changes also reduced the length of time spent in acute hospital beds. Numerical decline has been long-term, since a peak in the early 1960s. Between 1979 and 2012 there has been there been an overall decline of 59%. This was composed of a 35% fall in acute beds, with much larger reductions in geriatric (65%), psychiatric (74%), and maternity (58%) beds, hardly offset by a small rise in numbers of day beds (for very short stays) to 8.7% of the total bed stock by 2016/17.[74]

What can the welfare economics model contribute to explaining these different patterns? A 'state failure' argument was certainly introduced by proponents of private hospitals, initially in response to empirical evidence of two areas of difficulty for the NHS—waiting lists, which were held to be caused by the moral hazard inherent in a free service, which produced excess demand, and the continuing spatial

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inequities of funding, beds and specialist care, which the reform still had not alleviated by the 1960s.[75] In the 1980s, as enthusiasm rose for privatisation, it was suggested these shortcomings might be obviated by commercialising hospital care, so that the price mechanism would adjust supply to demand more effectively.[76] Conversely, as Thatcherite austerity restrained public expenditure, the argument changed. Now it was proposed that fostering private hospitals would ease the burden of state insufficiency, by siphoning well-heeled patients off towards comfortable paying hospitals; this justified generous tax treatment for private insurance.[77] Subsequently, as NHS commissioning from the private sector increased, initially for ancillary services, and more recently for medical care, the emphasis changed again. Now the focus was on the greater efficiencies that a private hospital should be able to achieve, thanks to the spur of the profit motive so lacking in state institutions.[78]

The empirical evidence underpinning all this has been ambiguous and hampered by poor data. In the 2000s, economists evaluated the results of NHS contracting from 'independent sector treatment centres' (ISTCs). Critics had worried about 'cream-skimming', whereby ISTCs concentrated on less challenging procedures from which it was easier to make profit, thus leaving the NHS with more difficult, costly cases. There was some evidence for this, alongside the perceived benefits of driving down waiting lists.[79] More recently there have been claims that health outcomes were better in regions where commissioners have the greatest choice of alternative public and private providers; it is hypothesised that this is because competition has galvanised hospital managers to greater efforts. However, the outcome data are limited, the underlying regressions based on imperfect mapping of hospital catchments onto mortality data, and the causal pathways uncertain.[80] In sum, the survival and growth of the private sector needs to be understood less in terms of its positive attributes *vis a vis*

state failure. More important has been the political context in which it has operated, with accommodation from the left and positive encouragement from the right.

What about the numerical decline of hospital beds? Neither state failure, nor state successes seem particularly apposite as explanations. Dehospitalisation has been a feature of all advanced industrial economies, with the reasons primarily located in technological change, the greater efficiency of surgical procedures and pharmaceutical therapies, particularly of psychiatric illness. It is certainly arguable that British deinstitutionalisation has gone comparatively further and faster: in 2004, for example, the UK had about 3 acute beds per 1,000 population, whereas European peers like Belgium (7 per 1,000), Germany (6.5) and France (4.7) had more. Given that these nations had mixed insurance modes of health funding and plural hospital ownership, then it may be that the tendency of the single-payer NHS towards greater cost-containment has been a factor.[81] However, whether or not this has made the system relatively more vulnerable to shortages is dependent on other factors, such as the availability of social care accommodation, and the quality of treatment in primary and community settings.

With respect to psychiatric beds, the asylum's demise has been much debated by historians of madness. Their main focus has been on the medications that have underlain deinstitutionalisation, beginning with the antipsychotic chlorpromazine in the 1950s, and subsequently antidepressants.[82] Some countered this technological account with an emphasis on political economy. Was the real motive for Powell's 'water tower' speech a desire for a cheaper model of managing the disorderly nature of mental illness? Similar suspicions fuelled the critique of late twentieth-century community care. A cognate argument is that rather than providing a chemical 'cure', drug therapies work by altering intellectual and emotional processes in potentially harmful ways.[83] At its demise, the asylum has also had its champions, who

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elegised its humanitarian achievement in providing refuge and care. However, it would be difficult to conclude from all this that the imperative of restraining expenditure was distinctive to the statist NHS.[84] 'Decarceration' and the accompanying anti-psychiatry movement was a widespread phenomenon, spanning for example Basaglia in Italy, Foucault in France, Szasz, Goffmann, Kesey in the USA, and Laing in Scotland. If its common theme was state failure, then this was within a larger argument about the harmful effects of social control.

Finally, sociology provides another account of the hospitals' demise that is rooted in the concept of medicalisation and neutral towards sectoral type.[85] This begins from the argument that the hospital's long run transformation from refuge to clinic was a timebound phenomenon. As medicine staked a claim to knowledge based on pathology and bacteriology, spaces were needed in which medical practitioners had bodies readily available for analysis. By the mid-twentieth century, the status of biomedicine was assured, and with the decline of infectious disease the clinical gaze began to turn outside the hospital's walls and into the community.[86] The cancers and cardio-vascular diseases appeared to have preclinical causes, rooted in individual choices about behaviour and consumption, long preceding their morbid manifestation. The result was an increasing medicalisation of society itself, in which a 'surveillance medicine' sought to turn unhealthy consumers into virtuous self-governing subjects.[87] Whether this claim has any predictive power remains to be seen. The secular decline of hospital capacity has certainly continued since it was enunciated, although the rate has slowed markedly since 2010. The advantages for fixed costs of concentrating expertise in large institutions seem likely to persist. For example, the long run retreat from home births in favour of increasingly large hospital obstetric units remains almost complete, despite the safety advantage now having disappeared (proportion of births at home: 1927—85%; 1948—46%; 1965—28%; 1981—1%; 2010–2.5%).[88]

**1948 to 2010: NHS hospitals under the state—success or failure?**

In arguing for the NHS, Bevan had claimed that centralising and nationalising the hospital system would eradicate the inequities of access determined by place and local prosperity. It would universalise the best, bring serenity 'in place of fear' and deliver efficient, effective care.[89] The assumption behind this, and in the policy documents that had informed the debate, was that system integration under responsible administrative bodies, coupled with stable financing, would inevitably bring this about. How well did the public hospitals perform in the era of control by the central state?

Before attempting a general appraisal, it is important to note that hospital policy-making, however good or bad, took place within a budgetary envelope set from above. With charity now consigned to marginal areas, and income from the pay beds minimal, the scope of activity was determined by the annual financial settlement. In almost every year since 1948, this Exchequer subvention for the NHS included a real increase. However, as is well known, the rising proportion of older people in the population, and hence the overall prevalence of morbidity, has driven a commensurate rise in demand. Technological costs and culturally determined expectations of service have also fuelled this. However, the pace of real increase to the NHS budget has been quite variable over time, with three periods—the early 1950s, the 1980s-1990s, and the 2010s—times of relative austerity.[90] All three periods have been episodes of Conservative government, in which NHS expenditure played second fiddle to broader economic policy considerations.

International comparison also casts light on the financial constraints within which hospital policy must be judged. As in Table 5.4, this consistently shows British health expenditure to have been relatively modest when set against peer nations, whether viewed in real per capita terms, or as a proportion of GDP.


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***Table 5.4: Current health expenditure (public and private) as share (%) of gross domestic product, UK and comparator nations***

| | 1970 | 1980 | 1990 | 2000 | 2010 | 2017 |
|---|---|---|---|---|---|---|
| France | 5.2 | 6.7 | 8.0 | 9.5 | 11.2 | 11.5 |
| Germany | 5.7 | 8.1 | 8.0 | 9.8 | 11.0 | 11.3 |
| Japan | 4.4 | 6.2 | 5.8 | 7.2 | 9.2 | 10.7 |
| Sweden | 5.5 | 7.8 | 7.3 | 7.4 | 8.5 | 10.9 |
| United Kingdom | 4.0 | 5.1 | 5.1 | 6.0 | 8.5 | 9.6 |
| United States | 6.2 | 8.2 | 11.3 | 12.5 | 16.4 | 17.2 |

Source: OECD. Stat URL: https://stats.oecd.org/Index.aspx?DataSetCode=SHA# 19 May 2019

Two conclusions are possible. One is that the NHS model has been particularly suitable for maximising efficiency and preventing waste. The other is that this kind of single payer, centralised system has been more vulnerable to under-funding than those based on social insurance (Germany, Japan), local taxation (Sweden), or plural sources (United States). Until the 1990s, comparative health outcome data was limited and tended to support the former; since then however, Britain's poor ranking against indicators like avoidable mortality and cancer survival rates has inclined judgment to the latter.[91] If so, then it is here that the real 'state failure' of the NHS model lies, with its 'institutionalised parsimony' and vulnerability to Conservative retrenchment. [92]

The financial constraints of the 1950s explain the initial difficulties faced by the NHS hospitals, when regional health boards (RHBs) and their subsidiary hospital management boards (HMBs) found themselves unable to implement development plans due to lack of resources. Indeed, capital expenditure in the 1950s ran at a lower level than in the 1930s. This though is explicable in terms of

post-war austerity, when social spending on health took second place to that on council housing and school building. Within this context the newly integrated management structure did nonetheless deliver some achievements. Annual accounting became standardised and systematic. Savings from fixed costs for energy and laundries, and from bulk order of food and supplies, could now be obtained by HMBs, which mostly contained a cluster of hospitals. Regional treasurers monitored comparative costings and alerted institutions to areas of potential waste. Clinical management committees planned the distribution of specialists within the region, ensuring that expertise became better allocated in light of estimated need (though inter-regional disparities remained).[93] Alongside this came the capacity to manage the overall hospital stock, for example to further the goals of geriatric medicine, or to repurpose the increasingly redundant infectious diseases hospitals.

State direction became more ambitious in the 1960s under Enoch Powell's Hospital Plan. In addition to the asylum closures, planning sought to establish optimum bed to patient ratios, then to meet these through a network of district general hospitals, which would combine acute, geriatric, psychiatric and other specialty beds. Historical verdicts have been unkind to the Plan, though for its execution rather than its ambition. It transpired that Britain had neither the building capacity, nor sufficient technical expertise, nor the sustained public investment capital to support the programme, and much went unfulfilled.[94] A further problem followed the reduction of geriatric beds (based on a contestable ratio), which was made without proper reference to the capacity of social care in local government to provide complementary services. This was where the 'bed-blocking' phenomenon began, as the NHS vied with local authorities to shunt infirm patients, and their associated costs, across the imprecise health/social care boundary.[95] Here the problem was not state failure per se,

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but rather Bevan's decision to create bespoke administrative structures for the NHS, instead of situating hospitals within local government, where they would have sat alongside community care.

Faith in statist system planning continued into the 1970s, when the problem of spatial inequity was finally tackled by the 'RAWP'—a population-based formula for allocating funding to the regions and subsidiary districts. This was politically controversial for it meant moving resources away from the traditionally well-funded regions of London and the Home Counties to the provinces. The mid-1970s also saw a more concerted attempt to improve equity between different areas of the NHS, for the 'Cinderella services' of geriatrics and mental health had hitherto received disproportionately less funding than acute medicine. The programme budgeting initiative began an incremental adjustment towards those areas, again in response to a calculus of need. In both cases this represented successful, decisive action to overturn a stasis built into the system by history, and it did not emerge *deus ex machina* from state processes. It depended on conviction leadership by Labour politicians Barbara Castle and David Owen, and also on the emergence of experts able to frame and implement highly technical policy.[96]

From the 1980s a raft of policies was introduced that explicitly invoked state failure in their justification. The early Thatcher governments sought to improve efficiency and cost effectiveness by introducing management techniques from the private sector, and by treating patients more as customers whose wishes and needs merited more attention. Notions of 'provider capture' were expressed by theoreticians of the new public management, though the political discourse was more focused on resolving unstable industrial relations and upping productivity. First came the principles of Rayner scrutinies—target setting, and holding regional heads to account—coupled with the Korner health informatics initiatives. Next was the Griffiths

Report, inaugurating the replacement of consensual decision-making by general management under a single leader. A related attempt to import a new cadre of managers from the business world was only partially successful.[97]

Then in 1991 came the 'internal market', and a more decisive step away from a vertically managed, statist hospital system. The idea was to create a hybrid structure, which retained state ownership and financing, but mimicked market dynamics. It did so by obliging hospitals to price and sell their services to purchasing bodies, at first mainly in the form of regional and local health authorities, but increasingly of locally clustered primary care providers. The New Labour government retained this model, though replaced the language of 'purchasing' with 'commissioning'. This acknowledged the reality that there was little actual 'market' competition, because in most places purchasing was monopsonistic, and providing monopolistic. Gradually this was modified through ISTCs and what came to be called the 'any qualified provider' scheme, which encouraged commissioning from private sector bodies. Commerce was also to be the engine of capital improvement, with a 'private finance initiative' (PFI) now the norm for new building. This operated through government agreeing long-term contracts with private companies to build and manage hospitals, and resulted in a rapid expansion and renovation of the stock in the Blair/Brown years.

Has the performance of NHS hospitals under this policy regime borne out the driving assumptions of state failure and market strengths? The evidence is mixed. The new public management reforms of the 1980s did not prevent a growing public sense of crisis (arguably driven by underfunding) that in turn propelled the late Thatcher government towards more radical change.[98] Nor did early evaluations of the internal market show strong evidence of greater productivity. Part of the problem was that commissioning was complex and difficult, with the advantages of price information lying on the providers' side; also,


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its total cost within the system was opaque, rendering a historical cost/benefit appraisal impossible.[99] Considerable criticism has also been directed against PFI, which locked taxpayers into some costly and disadvantageous contracts, just as innovative approaches were moving care out of hospitals. As for patient satisfaction, public opinion data shows that this has moved closely in step with funding levels, not structural reform, rising significantly during the Blair years as Labour increased inputs.[100] All that said though, commissioning has become settled policy, and medical professionals generally approve the empowerment of primary care on the one hand, and the greater cost-consciousness of hospitals on the other.

It should also be noted that alongside this incorporation of market dynamics has been a strengthening of the state's armoury of control over doctors. The National Institute of Clinical Excellence (NICE) was established in 1997 to approve drugs and therapies, constraining liberty of prescription and treatment.[101] This was accompanied by Clinical Framework Guidelines, which sought to standardise activities according to best practice. The use of targets and published league tables of hospital activity was the state's effort to incentivise improvement through 'naming and shaming'; the initial use of this strategy in England seemed to be delivering results, but later research suggested no sustained effect.[102] Similarly, hospitals now had to accept the publication of 'patient reported outcome measures', which revealed success rates of different procedures. Finally, although the 2012 Health and Social Care Act attempted to remove the last vestiges of hierarchical administration, this quickly proved unsuccessful. The aim was to abolish regional authorities, so that the hospital trusts and 'clinical commissioning groups' would become free agents, operating mostly autonomously, with only light touch regulation from the central state.[103] Yet almost immediately regional authorities had to be reinvented as Structural Transformation Plan areas.[104] Integrated planning, it transpired, was necessary after all.

In sum, although state failure was much invoked in recent years, the evidence for its existence is not compelling. Moreover, administrative and political preference led the British to retain a statist system, but seek to improve it by making it more responsive to price and demand. Again, it is not very clear whether these strategies have really achieved their goal. In 2010, as New Labour faltered, NHS indicators of productivity, waiting times and satisfaction were all extremely positive.[105] However, it remains perfectly plausible that this is explained by the sustained funding increases of 2000-2010, rather than by the internal market model of the Blair/Brown years.

## Conclusion

The main focus of this discussion has been the changing balance of the public, private and voluntary sectors in the history of the British hospital. It has interrogated a conceptual model drawn from the welfare economics literature which proposed that each sector has certain attributes. The hypothesis was that in the medical field, there are some things that the private hospital can do well, but other things it does badly, and so too for the voluntary and the public hospital. To explain change then, we might confirm empirically the existence of these attributes, then look for evidence of shifts in opinion about their relative desirability.

In applying this model to the long-run pattern of change it does seem to offer some helpful insight, at least based on the British case. For example, there was the historic marginality of the private hospital, initially important in mental health care, but quickly superseded, and retaining only a small share of general hospital activity, including under the NHS, when it served wealthier individuals seeking greater

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comfort or speedier attention. Instead, the state and voluntary sectors were always dominant in hospital provision, because some form of collective arrangement was needed to regulate financing, above and beyond an individual's capacity to pay fees. The state's importance was in marshalling resources for marginal groups that sickness had cast outside the labour market, and whose distress needed to be managed, for reasons of humanity and social stability. The voluntary hospital emerged to provide care for sick people within the labour market, and was less discriminatory.

However, the welfare economics framework did not seem sufficient to explain moments of significant political transition, other than as general context. Instead, to reach a satisfactory account of change was to acknowledge more complex patterns of causation, in which social and political history mattered as well as economic. This raises the question of whether the positivist claims on which the model draws are valid. Instead perhaps its assumptions about inherent attributes are chimera—either descriptions of transitory phenomena, or normative judgments? International comparison should provide further insight into this question, and hence into whether this way of conceptualising the hospital sectors is useful for understanding historical change.

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