

# Introduction

In 1948 an animated public information film called *Your Very Good Health* explained the benefits of Britain's soon-to-be-introduced National Health Service (NHS).<sup>1</sup> It portrayed two different categories of hospital patient. The central character, Charley, says he is 'on the panel' as he cycles through an optimistic impression of a new town.<sup>2</sup> The narrator asks him to imagine that he fell off his bike: 'You'd be carted off in an ambulance, which might cost a couple of quid. And then you'd have to pay the hospital, too.' After he is convinced the new service will benefit him, Charley asks about 'old George up the road', who we first see walking past, wearing a bowler hat and carrying a brolly. When Charley asks him what would happen if he fell off a ladder he replies: 'I should call my doctor and have a private ward at the local hospital.' After the narrator describes the possibility of a series of specialist referrals and mounting payments, George is relieved and convinced that the new health service will benefit him too.

Why or how Charley would need to pay the hospital did not need explaining to a 1940s audience. Nor did the difference with the system under which George might incur mounting costs. Perhaps it was so ingrained in the everyday tapestry of British social life that it simply went without saying. The problem is that, looking back from the best part of a century later, we do not really know what went without saying. It is all too easy for those of us who have grown up with the NHS to anachronistically impose our own assumptions, either that things were the same or that they were different, onto the hospital system operating before 1948. We might assume that historians would be wise to this, but too often when they refer to payment in the pre-NHS hospitals they fall into precisely this trap. Although the abolition of payment became

the most distinctive and widely recognised feature of the NHS, we never ask, or else take for granted, what the predecessor of a health service *free at the point of use* was, how it worked, or what it meant to hand over money to the doctor or the hospital.

For an explanation we can turn to Geoffrey Finlayson. Where Richard Titmuss observed that ‘welfare systems ... reflect the dominant cultural and political characteristics of their societies’, Finlayson added that so too do ‘studies of welfare systems.’<sup>3</sup> British historians living and writing in the era of the NHS have given questions of payment less attention than American historians, for whom payment and insurance are a daily reality.<sup>4</sup> The influence of a historian’s context on the focus of their studies also explains the fact that British historians have increasingly started asking such questions since the turn of the century. By the time New Labour left office in 2010 it was the new rule that a ‘patient’s entitlement to NHS care should not be withdrawn as a result of purchasing additional care privately.’<sup>5</sup> This ‘quiet revolution’ meant that, in the words of a leader in *The Times*, ‘the era of truly universal NHS care came to an end in principle as well as in practice.’<sup>6</sup> This direction of travel was followed apace under the Cameron governments. In 2013, the *British Medical Journal* reported that 89 per cent of NHS acute hospital trusts (119 out of 134) were offering private or ‘self-funded’ services and that private work in NHS hospitals was expanding.<sup>7</sup> Ahead of the 2015 general election, Conservative pollster Lord Ashcroft found mixed views on the NHS. Providing services free at the point of use was seen as its second most indispensable feature, after only emergency care, yet 50 per cent wanted the government to consider charging for some services.<sup>8</sup> What might those considerations be based upon? Fragmentation of NHS service provision has made it significantly harder for the government (or anyone else) to gather information about the situation on the ground, which leaves abstract theory or international comparison as the only options available – unless we look to the past.

This book does just that by examining the payment systems operating in British hospitals before the NHS. An overview of the British situation is given in chapter 1, locating the hospitals within both the domestic social and political context, before taking a wider international view. Chapter 2 sets up the city of Bristol as a case study to explore the operation and meaning of hospital payments on the ground. It places the hospitals firmly within the local networks of care, charity

and public services, shaped by the economics and politics of a wealthy southern city. The options, obligations and experiences of Charley are considered in chapter 3 and then those of George in chapter 4; with particular attention to how the hospital payment schemes they would have navigated were introduced in our case study city. Treating the two in separate chapters reflects the distinction drawn between and separation of working-class and middle-class patients as a defining characteristic of the system that emerged over the early twentieth century. Chapter 5 will then step back to consider the social meaning of payment in such a system.

Essentially this book looks at four new arrivals in British hospitals from the late nineteenth century, each of which became commonplace in the interwar years. These were: patient payments, hospital almoners, hospital contributory schemes and middle-class patients. None of these were small changes, and the impact they had upon the philosophy of the hospitals is here recognised and characterised as a shift from a moral to an economic code of conduct. Yet it is argued that new systems of class division merely replaced old ones, ensuring such distinctions remained at the heart of the hospital system and serving to mitigate and mediate the rise of universalism in British healthcare.

### Charity and change

There have only been three decades in British history (at the time of writing) when it was the norm for hospital patients to make some payment to the institution where they received treatment, those between the end of the First World War and the establishment of the National Health Service. Although fever hospitals and specialists were already admitting patients from across the classes in the final decades of the nineteenth century, many of those who could avoid hospitalisation did so at almost any cost. While some institutions may have asked their non-pauper patients for a contribution and others may have provided some services for a fee, the fact that most patients were poor ensured that payment was far from the norm until the 1920s.<sup>9</sup> Payment was then ended as standard practice in 1948 when admission and treatment mostly free at the point of delivery was guaranteed to all under the NHS.<sup>10</sup> In between we find the short history of commonplace hospital payments, which can be understood both as an effort to manage

the transition from caring for the poor to treating the whole community, as well as an abandoned alternative to socialised medicine.

Institutional medical care before the NHS was provided by a complex and constantly evolving mixed economy of healthcare. This included various categories of public hospital, each for specific groups. Poor law infirmaries gradually broke away from the workhouse, while sanatoria were set up to quarantine and treat those with a range of infectious diseases. Although these public institutions provided most of the nation's hospital beds, and dominated those for the chronic and aged sick, it was only in the interwar years that local initiatives by the most progressive authorities gave way to a conversion of poor law infirmaries into community hospitals on a much wider scale.<sup>11</sup> The old practice of stripping voting rights away from those admitted to a workhouse on medical grounds was abolished in 1885 and poor law infirmaries became important providers of maternity care, which Lara Marks suggests had done much to lessen the stigma attached to them by the 1920s.<sup>12</sup> Yet, when taking over those same infirmaries in the 1930s, local politicians were all too aware that one of the big tasks facing them was to end the significant stigma that remained.<sup>13</sup> Alongside these public hospitals, most acute medical care was instead delivered in voluntary hospitals, despite the fact they accounted for only approximately one-quarter of hospital beds, with many of these clustered in the large teaching hospitals.<sup>14</sup> The voluntary hospitals were charities, often established in the eighteenth and nineteenth centuries, to care for the sick poor. They were 'voluntary' in the sense they were founded and supported by philanthropic donations, though funding from other sources including public grants was growing in the early twentieth century.<sup>15</sup> They were also entirely independent of the state as well as of each other. They ranged from elite and grand institutions linked to medical schools, where the pioneering treatments of the day were often tested, to small cottage hospitals, where local doctors dabbled in minor surgery. Across this diversity, the voluntary hospitals can only be understood on their own terms if they are understood as charities.

At the turn of the century there was only rarely any need for anyone who could afford their own treatment to enter either public or voluntary hospitals. Yet this was changing. When the Ministry of Health was established in 1919, a committee was set up to examine the changes taking place and what medical system would be needed as a

consequence. The interim report the following year explained that the change was essentially down to advances in medical science and technology:

In days gone by such conditions as appendicitis were treated with poultices and drugs in the patient's home. Now they are treated by operation, which is more effective, but requires more equipment, a team of workers, and a larger expenditure. Such conditions as diseases of the lungs formerly received clinical examination and treatment by drugs. They may now require, in addition, the attention of the pathologist and the radiologist. This means greater efficiency, but more organisation and higher cost.<sup>16</sup>

The early twentieth century was a time when medicine simply became able to do more and became far more dependent upon the technological capacity of the hospital. It saw considerable increases in demand for hospital admission, especially at the voluntary hospitals with their higher reputation. Yet hopes the new Ministry of Health would build a national network of new facilities to meet that demand were short-lived. Lloyd George's wartime coalition had been extended into peacetime, but became far less ambitious in domestic policy as Conservative voices calling for retrenchment came to dominate.<sup>17</sup> Instead, it was left to local health committees and individual institutions up and down the country to respond to and embrace the new era of hospital medicine. The four new arrivals in the hospitals can all be understood as the hospitals themselves seeking to adapt to and manage these changes.

#### *Patient payments*

One of the ways voluntary hospitals sought to diversify their funding, in the hope of increasing income to meet the challenges of the coming era of mass medicine, was by bringing in patient payment schemes.<sup>18</sup> This was not entirely new. The precedent had been set with the admission of private patients in London and occasionally elsewhere in the late nineteenth century, but the interwar years saw the establishment of payments for all categories of patient rolled out far more widely.<sup>19</sup> Their introduction may appear, upon first glance, to have ensured the voluntary hospitals at least were operating a system of private healthcare in the interwar years. However, we should not assume, simply because payment was involved, that this was a commercial arrangement. It is

important to consider what payment actually meant in practice. Although the schemes varied from hospital to hospital, we can discern some typical features; three of which are especially relevant here. First, rather than covering medical services payment went towards the cost of maintenance, while the doctors continued to offer their services gratuitously. Rather than a ‘medical fee’, therefore, this should be understood more as a ‘hospital boarding charge’. Second, at a typical rate of around one guinea per week (twenty-one shillings) for inpatients, payment covered less than one-third of the actual cost.<sup>20</sup> Far from being ‘for profit’ this was still heavily subsidised care. Third, a system of exemptions and reductions ensured payments were not a barrier to access. Pre-NHS hospital payments were less private medical fees and more a system of means-tested medical charity.

#### *The Lady Almoner*

The figure appointed to administer the new payment schemes was the Lady Almoner. Gradually between the 1930s and the 1960s the almoner would be rebranded as the medical social worker, but the original name is an allusion to dealing with money in the sense of distributing alms. The first hospital almoners were co-opted from the Charity Organisation Society, which sought to instil discipline in the Victorian world of philanthropy.<sup>21</sup> By the time of the NHS, the almoner was dealing with various aspects of after-care and social support that would fall into the fields today of not only social work, but also occupational health. However, the first appointment at the Royal Free Hospital in 1895, and others across the capital at the turn of the century, were focused on preventing abuse. In this case, ‘abuse’ meant the free admission and care of those who could afford to pay, and were not the intended recipients of medical charity.<sup>22</sup> Her job (as hospital almoners were almost always women) was not to decide who should receive treatment, but to determine the terms of admission. She could recommend people be sent instead to the workhouse if their circumstance was primarily one of poverty rather than sickness, or exclude those not poor enough for the hospital’s charity, but usually her task was one of deciding what rate of payment to ask for. Even while at times resented, there is no real evidence the decision of the almoner or the request for financial contribution was resisted.

*Hospital contributory schemes*

There was an alternative to the almoner's assessment, with the questioning of a middle-class social worker and possibly a significant lump sum asked. Hospital contributory schemes were mutual societies which operated by taking a deduction of typically two or three pence per week from their members' wages; in return they paid any hospital fees for them if they were admitted.<sup>23</sup> Further definition can be somewhat elusive, not least because of their varied origins. Some developed out of charitable Hospital Saturday and Sunday collection funds, others were rooted in workplace collections, and in some cases one or more hospitals actually established schemes directly.<sup>24</sup> Schemes in different areas also adopted a wide variety of policies. For example, some schemes such as those in Newcastle and Glasgow pushed for an 'open door' policy, whereby once they had provided the funding, access was universal and treatment was free at the point of use. They bypassed the almoner system at an institutional rather than individual level and have thus often been seen as forerunners of the NHS.<sup>25</sup> Meanwhile, others adopted a style more like that of commercial insurance, including a range of additional benefits in either cash or kind.<sup>26</sup> While both contributory schemes and the almoner's assessment provided ways for working-class patients to make a financial contribution to the hospital, membership of a scheme did allow a degree of empowerment in how that contribution was managed.

*Middle-class patients*

A system of income limits barred middle-class patients from admission to the ordinary wards of the hospitals, but increasingly over the early twentieth century the voluntary hospitals and some public hospitals set aside space for those who could afford to pay, usually in a private room. The far higher charges for these private patients were compulsory and not adjusted in keeping with their circumstances, and an additional fee would need to be negotiated with the doctor or surgeon. This is perhaps the area of hospital provision where we might expect the most growth, given the advances of medical science that increasingly made treatment in the home evermore unrealistic and the fact that, in difficult financial times, this was the only way in which hospitals could actually turn a profit. However, it appears that the voluntary hospitals were

either unwilling or unable to exploit this attractive new market, with the medical profession often in favour of maintaining a division between private and hospital work. On the eve of the NHS, private beds only accounted for 7.2 per cent of those across Britain's voluntary hospitals. The lower level of private provision in the public hospitals, where there were more beds overall, is not so easy to identify. However, based on fragmentary statistical evidence discussed further in chapter 4, we can estimate that only 3 to 4 per cent of all hospital beds in Britain before the NHS were private beds for middle-class patients. As well as being limited in scale, private provision was heavily concentrated in the south of England. In the work of the hospitals, especially further away from London, middle-class patients remained marginal throughout the period.

#### *Organising principles*

Two core principles will be discussed as underpinning these four new arrivals in British hospitals. The first will be termed *economic reciprocalism*. This is essentially the notion that payment can be incorporated into the social dynamics of philanthropy, where there is always a social hierarchy of expectations involved. The gift can never be returned exactly, but demonstrations of religiosity, sobriety or deference might be elicited by way of reciprocity.<sup>27</sup> What is peculiar about the brand of reciprocity we find in the hospitals during this short period of three decades is that a patient's deservingness to receive free or philanthropically subsidised care could be demonstrated by means of paying their way, or at least being prepared to pay. There was a new financial focus, but the same dynamics of deference. Willingness to make a financial contribution became not only the mark of an appropriate recipient for medical charity, but in an age of mass hospitalisation it became the mark of a good citizen.

A combination of change and continuity also characterised the second principle of *class differentiation*. Where the hospital was previously a space for the middle and upper classes to fund and provide care for the sick poor, they too now might require hospital treatment. This might be expected to open up a new democratic era of in the social life of the hospital, but it did not. Instead, the separation of the classes and the provision of different services to each on a different basis became an internal event. The old divisions and distinctions were not so much brushed aside as brought within the hospital. Working-class and

middle-class patients may have been more often treated within the same hospital, but it was only their medical or surgical treatment that was the same. They were accommodated in separate and very different settings, with their admission governed by very different arrangements.

All of this amounts to a period of dramatic change, yet those changes were based on a reformulation of the traditional philanthropic principles underpinning the voluntary hospitals. Payment was crucial to a reformulated brand of medical charity, but not its abandonment.

### Notes

- 1 John Halas and Joy Batchelor, *Your Very Good Health* (Central Office of Information, 1948), <http://film.wellcome.ac.uk:15151/mediaplayer.html?0055-0000-4225-0115-0-0000-0000-0>, accessed 25 April 2016.
- 2 When Charley says he is 'on the panel', this is a reference to the National Health Insurance system, introduced by David Lloyd George in 1911. It was a compulsory state insurance scheme for many industries, where contributions by workers, matched by their employers and the state, entitled them to be seen by a doctor chosen from a local panel. Only in cases of tuberculosis and some maternity benefits were hospital services covered.
- 3 Geoffrey Finlayson, *Citizen, State, and Social Welfare in Britain 1830–1990* (Oxford: Oxford University Press, 1994), p. 1.
- 4 Charles Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Johns Hopkins University Press, 1987), pp. 237–61; David Rosner, *A Once Charitable Enterprise: Hospitals and Health Care in Brooklyn and New York, 1885–1915* (Cambridge: Cambridge University Press, 1982), pp. 122–45; Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), pp. 145–79.
- 5 Sir Bruce Keogh, 'Improving Access to Medicines for NHS Patients', 4 November 2008, 3, UK Government Web Archive, [http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_090087.pdf](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_090087.pdf), accessed 25 April 2016; Mike Richards, 'Improving Access to Medicines for NHS Patients' (Department of Health, November 2008), UK Government Web Archive, [http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_089952.pdf](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_089952.pdf), accessed 25 April 2016.

- 6 'A Quiet Revolution: Co-Payments Are an Essential Part of the Future of the NHS', *The Times*, (5 November 2008).
- 7 Gareth Iacobucci, 'A Sixth of Hospitals in England Have Expanded Private Patient Options This Year, the BMJ Finds', *British Medical Journal*, 347 (17 July 2013), <http://www.bmj.com/content/347/bmj.f4524>, accessed 25 April 2016.
- 8 Michael Ashcroft, 'The People, the Parties and the NHS' (Lord Ashcroft Polls, January 2015), <http://lordashcrofthpolls.com/wp-content/uploads/2015/01/The-People-the-Parties-and-the-NHS-LORD-ASHCROFT-POLLS1.pdf>, accessed 25 April 2016.
- 9 For examples of payment in nineteenth-century hospitals, see Jonathan Reinartz, *Health Care in Birmingham: The Birmingham Teaching Hospitals, 1779–1939* (Woodbridge: Boydell Press, 2014). On the limited payments taken in poor law hospitals, see Keir Waddington, 'Paying for the Sick Poor: Financing Medicine under the Victorian Poor Law: The Case of the Whitechapel Union, 1850–1900' in Martin Gorsky and Sally Sheard (eds), *Financing Medicine: The British Experience since 1750* (London: Routledge, 2006), pp. 100–1.
- 10 For the best concise introduction to the history of the NHS, see Charles Webster, *The National Health Service: A Political History*, 2nd revised edition (Oxford: Oxford University Press, 2002).
- 11 For a fuller overview of these different areas of healthcare, see Steven Cherry, *Medical Services and the Hospital in Britain, 1860–1939* (Cambridge: Cambridge University Press, 1996), pp. 41–53.
- 12 Lara Marks, *Metropolitan Maternity: Maternal and Infant Welfare Service in Early Twentieth Century London* (Amsterdam: Rodopi, 1996), p. 198.
- 13 Bristol Record Office [hereafter BRO], Bristol Council Minutes [hereafter BCM], 1 January 1930, p. 250.
- 14 Robert Pinker, *English Hospital Statistics 1861–1938* (London: Heinemann, 1966), p. 2.
- 15 See Martin Gorsky, John Mohan and Martin Powell, 'The Financial Health of Voluntary Hospitals in Interwar Britain', *Economic History Review*, 55:3 (2002), 533–57.
- 16 Consultative Council on Medical and Allied Services, 'Interim Report on the Future Provision of Medical and Allied Services' (London: Ministry of Health, 1920), p. 5.
- 17 For critical and more sympathetic assessments of Lloyd George's postwar social reforms, see respectively Philip Abrams, 'The Failure of Social Reform: 1918–1920', *Past and Present*, 24:1 (1963), 43–64; Kenneth O. Morgan, *Consensus and Disunity: The Lloyd George Coalition Government 1918–1922* (Oxford: Clarendon Press, 1986).

- 18 For a discussion of this broader diversification, see Gorsky, Mohan and Powell, 'Financial Health'.
- 19 Keir Waddington, *Charity and the London Hospital, 1850–1898* (Woodbridge: Boydell Press, 2000), p. 87; Reinartz, *Health Care in Birmingham*.
- 20 Bristol Royal Infirmary [hereafter BRI], *Report for 1921*, p. 20.
- 21 Lynsey Cullen, 'The First Lady Almoner: The Appointment, Position, and Findings of Miss Mary Stewart at the Royal Free Hospital, 1895–99', *Journal of the History of Medicine and Allied Sciences*, 68: 4 (2013), 551–82.
- 22 See Keir Waddington, 'Unsuitable Cases: The Debate over Outpatient Admissions, the Medical Profession and Late-Victorian London Hospitals', *Medical History*, 42:1 (1998), 26–46.
- 23 For an introduction to the schemes, see Martin Gorsky, John Mohan and Tim Willis, *Mutualism and Health Care: British Hospital Contributory Schemes in the Twentieth Century* (Manchester: Manchester University Press, 2006).
- 24 *Ibid.*, pp. 19–43; Barry Doyle, 'Power and Accountability in the Voluntary Hospitals of Middlesbrough 1900–48', in Peter Shapely and Anne Borsay (eds), *Medicine, Charity and Mutual Aid: The Consumption of Health and Welfare, c.1550–1950* (Aldershot: Ashgate, 2006), pp. 207–24; Stephen Cherry, 'Hospital Saturday, Workplace Collections and Issues in Late Nineteenth-Century Hospital Funding', *Medical History*, 44:4 (2000), 461–88.
- 25 Gorsky, Mohan and Willis, *Mutualism and Health Care*, p. 139.
- 26 Steven Cherry, 'Accountability, Entitlement, and Control Issues and Voluntary Hospital Funding c1860–1939', *Social History of Medicine*, 9:2 (1996), 215–33.
- 27 Alan Kidd, 'Philanthropy and the "Social History Paradigm"', *Social History*, 2:2 (1996), 186–7.