History & Policy-Strategy Unit discussion: historical evidence on the third sector and volunteering

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1. Summary

i. There is an extensive literature on the pre-NHS hospital system which is considered in relation to Lester Salamon's framework for evaluating non-profit provision as a method of delivery of welfare services. Salamon argued there were four main points of criticism: philanthropic insufficiency, paternalism, amateurism, and particularism. There is strong evidence for all of these from the pre-NHS era; the emphasis here is on insufficiency and particularism.

ii. In a shorter historical frame of reference evidence has been collected on volunteering since the 1980s and most frequently and consistently since the mid-1990s. This shows considerable underlying stability in the proportions of the population engaged in volunteering, and in the distribution across social strata.

iii. The suggestion that state intervention has crowded out voluntary initiative is not a question to which there is a straightforward historical answer. Preliminary work on trends in the foundation of charities (rather than registration dates) seems to imply long-run growth in voluntary effort throughout the post-war period but there also appear to be interesting sub-national variations in the distribution of new organisations.

2. The pre-NHS hospital system

Philanthropic insufficiency: there are optimistic readings of the pre-NHS era which often rely on anecdotal or selective evidence such as James Bartholomew's *The Welfare State We're In* (2004), or which exaggerate the comprehensiveness of existing arrangements (as in David Green's work: *Reinventing civil society*, 1993), ably criticised by Susannah Morris ("Defining the nonprofit sector: some lessons from history", *Voluntas*, 11, 2000, 25-43), who shows that his analysis was flawed by double counting).

In contrast, systematic analyses draw on data from the wartime Hospital Surveys and the Hospitals Yearbooks on over 1000 hospitals in the pre-NHS era for the period from 1891 onwards. Data from the latter have recently been made available online: see http://www.hospitalsdatabase.lshtm.ac.uk/ . Analyses show conclusively the significant variations in provision, finance and utilisation of charitable health care in England and Wales. One's chances of treatment varied by a factor of at least 5 depending on where one lived, and these variations were generally negatively correlated with need. There were considerable variations, in addition, in the asset base of individual hospitals, which affected their ability to ride out the adverse economic circumstances of the 1930s. In this regard it would be worth exploring the resilience and asset base of third sector organisations to gain a sense of likely effects of funding reductions.

In the interwar period, variations in provision were acknowledged, but there were few effective levers to direct resources into needy locations; indeed public intervention was vigorously resisted. Eventually, however, gaps in provision were closed through public intervention to address market failure (e.g. capital grants to hospitals in significantly disadvantaged areas (the “Special Areas” legislation in the 1930s), but more systematically through the efforts of local authorities).

A contemporary parallel might therefore be with the notion of "charity deserts" which clearly existed in the interwar period. In the present day, it is known that the distribution of charitable organisations varies considerably but it is questionable what the term "deserts" means in this context (communities might have few charities but this is not necessarily an index of charitable activity in those communities, while one would also have to look at the extent of public provision; furthermore, one would also need to look at "below-radar" organisations) and what might be done about it but the historical evidence does point to the role of public intervention in reducing some of the gaps in welfare provision.

After 1948, health authorities were not permitted to engage in systematic fundraising activities, but the restrictions on this were relaxed in 1980. We now have some 30 years data on the pattern of funds raised by such initiatives. Analyses of charitable funding for health-related causes and for NHS-controlled charities continues to display substantial variations unrelated to need so a policy question would be whether this distorts priorities.

Philanthropic particularism and amateurism: establishment of hospitals depended on an idiosyncratic range of influences rather than a systematic assessment of need. As a result there were established large numbers of small, inefficient and specialist units, with problems of duplication and poor-quality healthcare, indexed by significant inequalities in the availability of medical staff and modern equipment. Notwithstanding this, hospitals resolutely refused to collaborate with occasional exceptions in some major cities.

Philanthropic paternalism: by the late 1930s traditional forms of funding (charitable donations and legacies from the well-off) were at best static and growth was sustained by large contributions from the working class (the hospital contributory schemes). These initially generated huge enthusiasm -- attracting up to 11,000,000 subscribers by the late 1930s – and substantial voluntary effort but it seems that after the initial wave of participation, the pattern of engagement settled down and the schemes were run by small numbers of committed individuals. Our understanding is that this is largely because individuals came to see the schemes in an instrumental manner, as offering low-cost hospital insurance. Furthermore, notwithstanding the funding delivered by the schemes, control and governance of hospitals remained very much in the hands of philanthropic and medical elites.

After World War II, some of the hospital contributory schemes continued in existence and survive today as providers of low-cost health insurance but by and large the democratic and participatory elements that initially characterised them have disappeared. The evidence therefore suggests that while considerable enthusiasm can be mobilised, to sustain it requires a cause which will motivate people and which

will continue to do so; asking people to replace gaps in services left by a retreating state may not be a strong source of motivation.

Links to publications summarising this evidence are at http://www.hospitalsdatabase.lshtm.ac.uk/the-voluntary-hospitals-database-project.php#5 (note that some of these may not be available from non-academic sites; please contact John Mohan for PDF copies). A fuller summary, including bibliographic references, of an evidence review on the pre-NHS hospital system is available through an NHS SDO research programme end of project report (*A Literature Review on the Structure and Performance of Not for Profit Health Care Organisations*, online at http://www.sdo.nihr.ac.uk/projdetails.php?ref=08-1518-106 - see appendix 3 of that document for details of the historical evidence considered.

3. Evidence on trends in volunteering

We have reviewed a number of datasets from surveys which ask respondents whether and how frequently they engage in voluntary activity. These originate from different surveys and they pose questions in different ways but we now have evidence on a regular basis since the mid-1990s in the British Household Panel Survey (BHPS), since 2001 in the Citizenship Survey, and occasionally from other sources such as the General Household Survey.

This is a shorter and more recent time frame for historical analysis, but the underlying picture is one of considerable stability. Depending on the way in which the question is posed, estimates of volunteering will typically range from 10-20% of the population at one end of the spectrum to up to 40-45% at the other. There is little variation from year to year that is statistically significant. This does not support assertions that there has been a recent upsurge in engagement. The social patterning of voluntary activity also remains constant. There is little evidence of statistically significant geographical variation once the characteristics of communities are controlled for (e.g. the mix of population in different areas).

It is notable in addition that levels of volunteering have remained constant despite a significant expansion of third sector activity in recent years. This might suggest that efforts to stimulate volunteering have had no effect although it is equally plausible that levels of volunteering might have dropped in the absence of such efforts.

A positive interpretation of these trends would be that although there are social variations there is a genuine and substantial degree of participation in voluntary and community initiatives. A less optimistic view would look at the relationship between likelihood of volunteering and individual household characteristics (e.g. whether or not an adult has dependent children) and/or social network characteristics (e.g. whether or not someone is a member of a church). This would show that of the volunteer population, a high proportion have characteristics (dependent children, church membership) which governments cannot easily influence. Policy would therefore have to be directed at increasing engagement on the part of groups who, historically, have not had a great deal of involvement in volunteering. In addition, because of patterns of residential segregation, those groups most likely to volunteer do not necessarily live in those areas most in need so we need to consider the extent to which volunteering takes place across such socio-economic divides.

The comments in this section draw upon TSRC Briefing paper 6 (available at http://www.tsrc.ac.uk/Publications/tabid/500/Default.aspx); a fuller version of that paper, plus other papers on related themes, will be published by the TSRC in summer 2010.

4. Relationship between state intervention and the voluntary and commuter sector

It is sometimes argued that the growth of the welfare state "crowds out" voluntary and community initiative. What does the historical evidence tell us?

If nationalisation of the hospitals crowded out voluntary initiative, it did so for a good reason: to replace it with a more equitable system in which one's chances of treatment no longer depend on the caprice of charity. The fact that (as Bartholomew argues) the voluntary system included some hospitals with an international reputation providing high-quality treatment does not outweigh the very substantial weaknesses of the system once there was endorsement for the notion of an entitlement to health care.

But public provision has most certainly not resulted in a crowding out of voluntary initiative. The Register of Charities in England and Wales has only existed in its modern form since 1961, but the numbers of charities on the register has increased steadily as have the number of registrations. It is possible that this could be attributed to regulatory activity (e.g. the commission encouraging organisations to register) so an alternative to the numbers of registrations and the numbers of registered charities is required. We have developed a methodology for extracting foundation dates (technically, these should be better understood as the earliest date in an organisation's governing documents at which a legally identifiable document of some kind, such as a trust deed, came into existence) which appears to show a steady upward trend in the number of foundations of new charities from 1945 onwards. This trend applies regardless of which government was in power. There are occasional "blips" which we think can be explained by increases in regulatory activity by the Charity Commission.

Interestingly, however, there is some evidence that the local pattern of establishment of new charitable organisations varies between government terms of office: we think there was a strong negative gradient in the distribution of new formations in the Conservative years from 1979 to 1997, with the majority of new charities being founded in the most prosperous parts of the country, whereas under Labour from 1997 the imbalance between deprived and less deprived areas was much less notable. This could reflect the role of public initiatives such as spending on regeneration programmes.

We should also consider the relationship between voluntary initiative and markets: studies of health care systems show that non-profit service delivery has been squeezed by competitive pressures (notably in the USA) and the effects depend on the characteristics of local health care markets, forcing nonprofits to mimic their commercial competitors. There is similar, though less robust, evidence for non-profit providers of health care in the UK (see NHS SDO report, cited previously).