

Charitable fundraising and the NHS: policy and practice since 1948

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Introduction

To provide context for an understanding of Jimmy Savile's activities in relation to fundraising for NHS institutions, three issues are relevant:

1. The relationship between charitable fundraising and the NHS after 1948
2. The economic and social policy context of the early 1980s
3. The 1980 Health Services Act and subsequent developments in charitable fundraising in the NHS.

The following draws on research into NHS policy and planning, the pre-NHS voluntary hospitals, the contemporary role of charity in the NHS, and the present-day distribution of charitable resources.¹

¹ M. Gorsky, J. Mohan and M. Powell, 'British voluntary hospitals 1871-1938: the geography of provision and utilisation' *Journal of Historical Geography* 25, 1999, 463-82 <http://southampton.library.ingentaconnect.com/content/ap/hg/1999/00000025/00000004/art00162>; M.Gorsky & J.Mohan, *Don't look back ? Voluntary and charitable finance of hospitals in Britain, past and present*, London, Office of Health Economics, 2001 (not available online); M. Gorsky and J. Mohan, 'London's voluntary hospitals in the inter-war period: growth, transformation or crisis?', *Nonprofit and Voluntary Sector Quarterly*, 30, 2001, 247-75 <http://nvs.sagepub.com/cgi/reprint/30/2/247>; M.Gorsky, J.Mohan & M.Powell, 'The Financial Health of Voluntary Hospitals in Interwar Britain', *Economic History Review*, lv, 3, 2002, 533-557 ; J. Mohan, 'Voluntarism, municipalism and welfare: the geography of hospital utilization in England in the 1930s', *Transactions, Institute of British Geographers*, 28(1), 55-74. 2003 <http://www.blackwell-synergy.com/doi/full/10.1111/1475-5661.00077> ; J. Mohan, 'The caprice of charity: regional variations in finances of British voluntary hospitals, c. 1891-1944', in M. Gorsky and S. Sheard (eds), *Financing medicine: the British experience*, London, Routledge, 2006; M.Gorsky & J.Mohan with T.Willis *Mutualism and health care: British hospital contributory schemes in the twentieth-century*, Manchester, Manchester University

The relationship of charity to the NHS after 1948

Why, in a state-funded health service, did charitable fundraising re-emerge and how important was it to the health service and to individual health authorities and/or hospitals?

In fact, charitable funds never disappeared entirely from the NHS. Around 1100 voluntary hospitals were nationalised when the NHS was set up, but the teaching hospitals were permitted to retain control of their accumulated endowments, while the equivalent funds held by non-teaching hospitals were consolidated in a Hospital Endowments Fund and the proceeds from it distributed to individual institutions.

Furthermore, although Aneurin Bevan (the first Minister of Health in the post-war Labour government) prohibited the solicitation of charitable funds, NHS hospitals were never prevented from receiving gifts. The understanding was that people might offer small tokens of appreciation to hospitals and it would be churlish to refuse them. But there were restrictions in terms of what they could use charitable funds for. Because the statutory obligation of the NHS was confined to the treatment of illness, it was envisaged that charitable income could be used for patient welfare (comforts and amenities on wards), the welfare of staff (e.g. accommodation and social facilities), medical research (technically not a statutory obligation for the NHS) and illness prevention.

There was a prohibition on direct fundraising, and on the use of public money for charitable fundraising, until 1980. The rationale for doing so was that revenue allocations within the NHS were determined largely by the distribution of the capital stock, and therefore if new hospital facilities were established with charitable finance, the revenue would have to be provided to run them and this could distort resource allocation.

Voluntary effort was of course encouraged through the activities of Leagues of Friends, and within 12 years of the establishment of the NHS an article reported that at least 500 of these had been founded. By the late 1970s there were around 1300.²

The economic and political context of the early 1980s

The position on charitable fundraising changed after 1979 for a number of reasons.

Economic context: The economic context was not promising and public expenditure was strictly controlled. There were many exchanges about whether the NHS was indeed safe in the hands of the Conservative government. These mostly turned on the question of whether growth in expenditure was keeping pace with inflation, NHS costs (particularly the cost of new drugs and innovative treatments), and demographic pressures. For much of the period from 1979 onwards, at best, the NHS in England was just about keeping its head above water in financial terms.³

Capital spending was also held very firmly in check. It had been cut in over a third in real terms in the mid-1970s, and it then flatlined and did not recover for over a decade. In fact, in the absence of the proceeds of land sales, particularly in south-east England, investment would have declined still further. Figures 1 and 2 demonstrate this: figure 1 indicates the absence of significant real-terms growth while figure 2 shows the substantial drop in new construction in the early 1980s. The NHS capital stock was therefore not being renewed.⁴

Two further points are noted which may have had some influence on the Stoke Mandeville situation in particular, as well as on voluntary initiative in the NHS in general. It is impossible to confirm these contextual observations without further primary research.

Firstly, within an overall no-growth budget, the NHS in England was attempting to pursue a policy of resource redistribution, moving money away from inner-city areas where for historic reasons there were large concentrations of hospitals, to suburban and rural areas

² Mohan and Gorsky, *Don't Look Back?*, 91-113; J. Mohan, *A National Health Service?* (Macmillan, 1995), chapter 8; M. Lattimer, *The gift of health* (Directory of Social Change, 1996).

³ Mohan, *A National Health Service*, chapter 1.

⁴ J. Mohan, *Planning, markets and hospitals* (Routledge, 2002), chapter 8 and appendix A.

where the population was, by the late 1970s, growing rapidly. However, releasing resources for growth in such locations depended on rapid rationalisation of the urban hospital stock, which was always a controversial and time-consuming process. The resource allocation formula used (developed in the mid-1970s by the Resource Allocation Working party – hence the acronym, RAWP, by which it was generally known) was criticised in particular for its reliance on population estimates which were always a year or two out of date, and which were therefore likely to lag behind the reality of population growth.⁵ This meant that health authorities in the outer fringes of the south-east, where the population was growing rapidly, were always under pressure. There is evidence of this in Commons debates, and also in Parliamentary Select Committee enquiries.⁶ One health authority in such a position was the Oxfordshire Regional Health Authority, which encompassed Aylesbury Vale District Health Authority, including Stoke Mandeville. Reports in the early 1980s pointed to the great financial difficulties the region faced.

Secondly, the so-called "Cinderella" sectors of the health service struggled to compete for resources with acute hospital provision. As a long-stay institution, treating people for spinal injuries, it is likely that Stoke Mandeville was under-resourced.

The pressures on Health Authority finances were therefore such that it would not be surprising to suppose that explorations of alternative sources of income would be supported.

Social policy environment: The new Conservative government came into office making statements about the need to reduce public expenditure and the importance of voluntary effort. An early speech at the Conservative Political Centre in July 1979 by Mrs Thatcher shows this very well.⁷ However, this was not presented as a radical departure in policy; this stands in contrast to the rhetoric surrounding the "big society" that we witnessed in 2010.

⁵ DHSS, *Sharing resources for health in England: report of the Resource Allocation Working Party* (London, 1976).

⁶ Mohan, *A National Health Service*, chapter 4; J. Mohan, 'Uneven development, territorial politics and the NHS reforms', *Political Studies*, KXVII, 308-329.

⁷ M. Thatcher, 'The renewal of Britain', speech to the Conservative Political Centre, 6th July 1979; available at <http://www.margaretthatcher.org/document/104107>

The radical proposals of the Central Policy Review Staff (CPRS) for the welfare state in 1982 made reference to the possible role of insurance in health care provision but otherwise take no cognizance of the potential contribution of the voluntary sector.⁸

There is more evidence in the discussions of the Family Policy Group, led by Ferdinand Mount, of interest in the potential role of voluntary organisations, but no suggestion that substantial voluntary fundraising would be initiated or that public services would be handed over on a large scale to charities or other non-profits.⁹

Some prominent individuals and organisations met with the Prime Minister to discuss the potential role of the voluntary sector. One was Alec Dickson, the founder of Community Service Volunteers, who met with Thatcher to talk about the potential role of voluntary organisations in combating youth unemployment.¹⁰ There were some discussions about the possible contribution that the voluntary sector might make to health care, and some specific programmes were developed (e.g. Opportunities for Volunteering, which had a strong health emphasis, though its projects did not require large funding, and were often linked to an established infrastructure such as hospital Leagues of Friends).

Initiatives within the NHS

In the NHS, the government was promoting a degree of decentralisation (e.g. through formal initiatives such as administrative reorganisations (removals of tiers of administration in the service)) and the introduction of new management systems following the Griffiths enquiry into NHS Management in 1983.

A number of local initiatives took place. The government gave encouragement to individual health authorities to experiment with income generation initiatives – using their assets to raise money, for example through competing with other providers of services (e.g. using spare capacity in laundries and labs).

⁸ Central Policy Review Staff (CPRS), 'Long-term public expenditure options', TNA CAB 184/556, CAB 184/628.

⁹ Family Policy Group, 'Renewing the values of society', TNA PREM 19 / 783, PREM 19 / 1050.

¹⁰ TNA PREM 19 / 369

Reforms of management were aligned with this – the introduction of performance related pay systems facilitated the implementation of income generation targets. As one prominent manager said at the time, the sums generated might have been viewed as peanuts relative to the overall budget of the NHS, but “it's just that the moment, peanuts are bloody useful”.¹¹

There were proposals to hand over individual hospitals to charitable trusts. The most well-known was the Tadworth Court branch of the Great Ormond Street Children's Hospital, turned over to a charity in 1983; it now ranks among the top 200 charities in England and Wales by income.¹² Flexibilities available to new management included the ability to dispense with NHS terms and conditions of service. There were numerous other examples, mainly of small community hospitals in prosperous areas.¹³

Other elements of health care provision, particularly long-stay care, were also transferred to nonprofit companies. So the 1980s witnessed a number of initiatives at the local scale, not so much triggered by central edict, but enabled by a supportive policy framework in which managers and health authorities were encouraged to develop novel forms of service delivery and organisation.

Effects of the 1980 NHS Act

The 1980 Health Services Act allowed a significant expansion of charitable activity. There was a degree of post-hoc rationalisation in the policy, since the Stoke Mandeville appeal was already underway.

Health authorities were allowed to organise their own charitable appeals, and they were empowered to use Exchequer funds to pay for the costs of launching appeals – any costs incurred were to be repaid from the appeal proceeds.¹⁴ Funds generated were to be held by the organisers (i.e. the health authorities) as trustees for charitable purposes; it was not

¹¹ Mohan, *A National Health Service*, chapter 8.

¹² Author's calculations from Charity Commission data.

¹³ Mohan and Gorsky, *Don't look back*, chapter 4.

¹⁴ DHSS, *Health services management. Health services act 1980: fundraising by NHS authorities*, health circular HC(80)11.

necessary for the trustees to render accounts to the Charity Commission. Appeals at first were mainly for facilities that were argued to be outside normal NHS provision but there is some evidence and (as was argued by voluntary sector commentators at that time) that the boundary was blurring: appeals were also being established for capital projects and even for ordinary running costs. This was presented by the government as a modest extension of the existing powers of health authorities, but in fact there was a very positive endorsement of voluntary effort.

Though it was launched before the 1980 Health Services Act, it makes sense to consider Stoke Mandeville in this context. The specific trigger for the appeal was the realisation that there were significant structural problems in the building in the winter of 1979/80. Within a matter of weeks a large-scale appeal was announced, led by Savile. Prime Ministerial files show that some prominent private backers were being lined up and Gerald Vaughan, Health Minister, saw it as something which would promote understanding of the government's policy of involving the public in the health care system. The appeal led to discussions between Mrs Thatcher and Savile, the record of which was redacted in several places on 11th October 2012.¹⁵

During February 1980 Savile attended Downing Street for a presentation ceremony in connection with the NSPCC. At that time he pressed the Prime Minister about the question of tax deductions for charitable donations, an issue which was under active consideration by the government at the time. Subsequent correspondence referred to the Stoke Mandeville appeal – Savile met with Thatcher in January 1981 and asked for a government contribution towards the appeal funds. He also had lunch with Thatcher in March 1981 after which she was asked by one of her officials whether she had offered him any money for Stoke Mandeville and whether she had agreed to appear on Jim'll Fix It. In July 1981 Thatcher donated £20,000, the proceeds of a gala performance of "Anyone for Denis?", to Stoke Mandeville and the NSPCC,¹⁶ while in December 1981 a government contribution of

¹⁵ 'Communications with Jimmy Savile concerning tax deductions for charities following his fundraising for Stoke Mandeville Hospital', TNA PREM 19 / 878.

¹⁶ Thatcher Archive, <http://www.margaretthatcher.org/document/121667>

£500,000 was announced, in a speech celebrating the achievements of the International Year for Disabled People.¹⁷

Stoke Mandeville was probably the largest fundraising appeal in this period (at least prior to the public appeal to support the Great Ormond Street Children's Hospital later in the 1980s) but it was not alone. There ensued a steady growth in the number of charitable appeals run by NHS authorities, and in the amounts of funds so raised. Aggregate statistics from Department of Health Annual Accounts suggest rapid growth.¹⁸

Without contemporary statistics on the relationship between charitable fundraising and the budgets of individual health authorities and trusts, it is difficult to establish how important such sources of income were to the financial position of individual hospitals. But in some places, one of which was Stoke Mandeville, charitable fundraising certainly played an important role. In barely 3 years over £10 million was raised for the reconstruction of the spinal injuries unit there (including the contribution from the government of £500,000). Had the entire £10 million been spent in one year it would have represented some 25% of the Oxford regional health authority's annual capital programme.

It's a very unusual example. Most of the available statistics show that there are some well-established variations between types of hospital and communities in terms of the amount of fundraising. Teaching hospitals, followed by acute hospitals, followed by appeals for technologically sophisticated pieces of equipment, tend to pick up most of the money. From the general pattern we would not expect an orthopaedic institution to attract substantial support. Yet even after the initial phase of the appeal, in the mid-1980s, Department of Health statistics show that Stoke Mandeville continued to attract large charitable donations. If we express charitable funds raised in relation to the populations of health authorities, Aylesbury Vale, which included Stoke Mandeville, was in the top 10% of district health authorities in the mid-1980s.

Comparable statistics for Broadmoor are not available from the source I have used.

¹⁷ TNA PREM 19 / 878.

¹⁸ The annual publication, *Charity Trends*, contains intermittent reports of these.

Subsequently, the main charities in which Savile was involved in relation to these hospitals continued to operate but on a smaller scale. There is some evidence of their activities from the Register of Charities – both were registered in the early 1980s (the Jimmy Savile Hospital Trusts benefiting the Leeds General in 1985, and the Jimmy Savile Stoke Mandeville trusts in 1981). But since our financial statistics from the Commission do not go back beyond 1995, all we can say is that those two charities have typically spent between £50,000 and £200,000 in a typical year.¹⁹

Information from their recent reports shows that these charities only had four trustees, all the same people, one of whom was Savile. It is not known what arrangements there were for governing their activities nor what negotiations took place between Savile and the relevant health authorities. These trusts could simply have been set up as fundraising vehicles with money being passed directly to the health authorities in question.

There weren't any equivalent cases of a celebrity-led appeal elsewhere. Such appeals were organised by individual institutions and take place on a local or regional basis. There may well have been celebrities involved as patrons or sponsors although contemporary commentators do not make anything of this point.²⁰ There were occasional high-profile individual donors such as Sir Philip Harris, the carpet magnate, who donated large sums to Guy's and St Thomas's, only for some of the money to be withdrawn when rationalisation of those hospitals was in prospect.²¹

Wider Implications

The extent of these fundraising activities, and their potential importance to the finances of the institutions in question, suggest a need for exploration of the arrangements set up by health authorities to manage funds such as those raised by Savile.

¹⁹ Figures derived from TSRC database compiled from the Register of Charities.

²⁰ L. Fitzherbert, 'Charity and the national health' (London, 1992); Lattimer, 'The gift of health'; M. Lattimer and K. Holly, *Charity and NHS Reform* (Directory of Social Change, 1992).

²¹ O. Dyer, 'Charities demand money back in Guy's changeover', *British Medical Journal*, v. 308, 935.

Voluntary sector critics of NHS fundraising in the 1980s and 90s had raised similar questions – e.g. about how the funds raised were actually managed, as well as what they were used for. For example Luke Fitzherbert argued that there were variations in the management arrangements for charitable funds with some health authorities simply absorbing the funds raised into their revenue budgets while others established separate trusts to oversee them. The complexity of management arrangements did not help – some health authorities had literally hundreds of separate individual appeals, often in the name of individual consultants who had received money from grateful patients. Eventually many of these were rationalised and consolidated in the early 1990s.²²

Responsibility for governance did not, of course, stop with the health authorities in question, so it is also relevant to ask about the understanding of the DHSS / Department of Health of the activities of Savile and his influence over the management of these institutions.

Figures 1 and 2

Figure 1: NHS capital expenditure, England and Wales, constant prices, 1950-1991

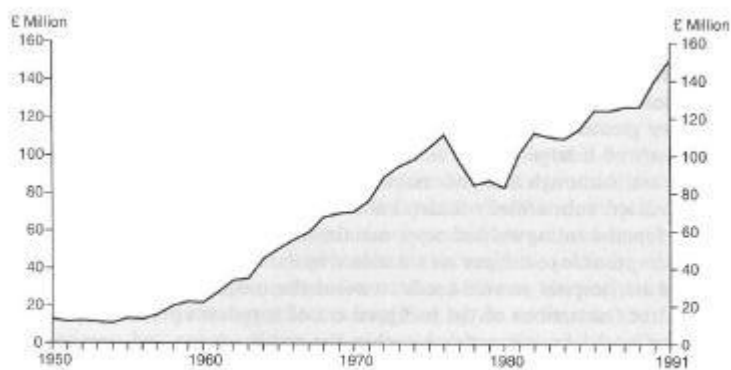


Figure A.1 NHS capital expenditure, England and Wales, at constant 1962 prices
Source: Summarised Accounts of Health Authorities

Figure 2: use of NHS capital expenditure, 1950-91

²² L. Fitzherbert, 'Charity and the national health' (London, 1992).

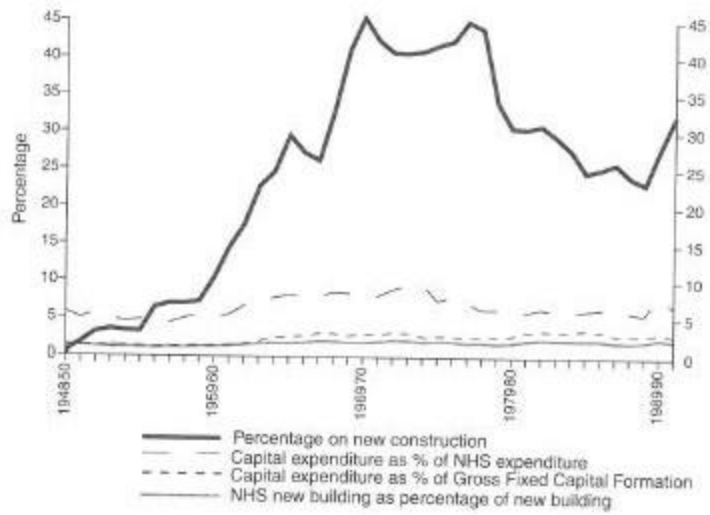


Figure A.2 Indices of change in NHS capital expenditure, 1950-91

Source: Summarised Accounts of Health Authorities (annual)