

## **Hospital volunteering and fundraising in historical context**

**Martin Gorsky, Centre for History in Public Health, London School of Hygiene and Tropical Medicine**

### **1. How might the historical context of hospital charity contribute to the Jimmy Savile investigation?**

- Jimmy Savile is alleged to have committed 50 offences in NHS hospitals, and one in a non-NHS hospice 'during his voluntary or fund-raising activities'. These were principally Leeds General Infirmary (16 offences), 1965-95, Stoke Mandeville Hospital (22 offences) 1965-88.
- The terms of reference for the NHS investigations seek background to his celebrity fundraising and volunteering for hospitals, to understand
  - his 'special access' and 'privileges; the non-reporting or non-investigation of complaints; the role of 'organisational culture and practices'; the weak 'governance and accountability' of his fundraising
- Anecdotal evidence suggests his fund-raising power gave him leverage over management. Why should this have mattered in a tax-funded NHS?
- Victims talk of him operating 'under the guise of charity'. Why did charity confer the status that allowed him to 'hide in plain sight'?

### **2. Beginnings: the long-term importance of philanthropy in the British health system**

- Historically there was nothing new or unusual about voluntary charity in the health field. Indeed prior to the start of the NHS (1948) around one-third of hospital beds were in the voluntary sector, including most leading centres of acute care and teaching hospitals. In London for example, they included Guy's, Barts, St Thomas's, University College, etc., and in the provinces the leading general and special hospitals. Many foundations date to the 18<sup>th</sup> and 19<sup>th</sup> centuries.

- ‘Voluntary hospitals’ signified charitable funding, staffing by honorary consultants and governance by volunteer boards. Donations and subscriptions came from aristocrats, big business, and the middle class generally.
- Charitable giving conferred power, social status and prestige. Those seeking a non-emergency admission, before c.1900, had to solicit a ‘letter’ from a subscriber; thus hospital charity created ties of patronage and loyalty in the fissile, rapidly changing society of industrializing Britain. Leadership in charity work also overlapped with that in local politics and the churches. Annual reports, newspaper coverage and events gave prominence and publicity to donors.
- ‘Celebrity’ fundraising was not principally from the arts and leisure world, although there are examples, such as J.M.Barrie’s gifting of the royalties from Peter Pan to Great Ormond Street, or Arsenal FC’s annual Charity Shield donation to the Royal Northern. Instead it signified patronage by royals, aristocrats and local politicians. Examples from 1930s London include:
  - Queen Charlotte’s Maternity Hospital 1930, royal family attended a theatre matinee, a Birthday Ball, a Baby Show, and a Silver Exhibition in aid of the rebuilding fund. Also “Evening Music Party” at 10 Downing Street and a “Persian Ball” at Grosvenor House attended by the Aga Khan.
  - King’s College, Royal Northern Hospitals annual or biennial festival dinner, at Claridges or the Savoy presided over by a titled aristocrat
  - Royal Northern Ladies League organized an annual Derby Ball, a Halloween Ice Carnival, and an Exhibition of Georgian Art.
- However, it was not just the rich, but the middle class and ordinary people too. Activities ranged from fetes, bazaars, and whist drives, to church collections to collecting boxes in pubs and clubs.
- ‘Visiting’ included visiting committees of trustees, typically local business people, who provided external oversight of charitable expenditure. Later ‘lady visitors’ became common, also acting as patient watchdog, though this

declined by 20<sup>th</sup> c. There were also choreographed, ceremonial visits by royals and peers for publicity and fundraising.

### **3. Before the NHS: the diffusion of hospital voluntarism throughout the community**

- Rising hospital costs from staffing, food, fuel, supplies, and building maintenance led to an insufficiency of hierarchical charity by the 1920s. To fill the gap came (typically) means-tested charges and membership of mass contributory schemes which relieved patients of such fees. These were extremely widespread, with perhaps 11 million British members on the eve of the NHS, paying a few pence each week. Large schemes included: Birmingham, c.700,000 members, 1938; Merseyside, c.400,000 members, 1946; and Leeds, c.246,000 members, 1947. Additional benefits included ambulance services, access to convalescent homes and spas etc.
- These schemes broadened the social base of fundraising, now based on workplace payroll deduction, and hospital management as fund representatives, typically trade union or friendly society leaders, now joined governing boards. They also reshaped 'visiting', both as community linkages and patient advocacy.
- They were also active in hospital fundraising. Leeds members, for example, carried out pub collections, put on an Annual Bank Holiday Hospital Gala in Roundhay Park, and organised through ward and district committees a series of carnivals and Sunday concerts.
- Thus before the NHS a widespread tradition of community voluntarism supporting hospitals had developed. This was partly through the charity of the rich or the middle class, but it also extended to all social groups and operated through working-class organizations. Hospital charity was a familiar part of popular civic culture, incorporating carnivals, fetes and processions.

#### **4. Into the NHS: the persistence of charity under a tax-based service**

- In 1946/7 the NHS Acts established a National Health Service for Britain which was intended to be comprehensive, universal and free at the point of use. It was funded partly by National Insurance contributions, but predominantly from general taxation. Given that the Minister now had a duty to provide services, why should hospital charity have survived at all?
- In the settlement most existing endowments were taken over by the state and distributed. However, to ease the political negotiations with the doctors, Aneurin Bevan, the Labour health minister, allowed the teaching hospitals to retain and control their endowments. Future charitable fund-raising was also permitted, out of respect for existing traditions.
- Charitable expenditure was confined to what are now called 'non-core NHS' areas: amenities for patients and staff, medical research, and building renovations and improvements. Clinical care and related accommodation and equipment were intended to be publicly funded, with a clear dividing line between the two areas.
- The model of charity governance adopted in the transition was 'corporate trusteeship', whereby the charitable funds were managed by the hospital board or an internal sub-committee, as before.
- Voluntary fund-raising has, however, continued to flourish and the arena of charitable expenditure continued to expand. Part of the reason lies with periods of resource constraint and low capital investment in the NHS. In addition to the 1980s, the early 1950s stands out as an era of austerity, with the introduction of prescription, ophthalmic and dental charges. Capital spending remained low through the 1950s, and only in the late 1960s was there significant new hospital building.

#### **5. The early NHS: continuing community attachment to hospital voluntarism**

- This was the context for the continuation of contributory schemes now primarily as cheap insurance covering dental, eye care, prescription charges and cash hospital insurance. The Leeds Hospital Fund, for example, fell to a

low of 158,000 in 1949, returned to over 200,000 by the 1960s and retained nearly 250,000 members by 1990. Local charitable support continued, with not only gifts of ambulances, books and Christmas presents to Leeds hospitals, but also support for local charities:

- Leeds Council of Social Service, Guide Dogs for the Blind, British Empire Cancer Campaign, the Leeds Children's Holiday Camp Association and the NSPCC.
- Alongside the continuing Hospital Funds, other schemes converted into small-scale Leagues of Friends, while the Women's Royal Voluntary Service was also active. Post-war hospital voluntarism represented both change and continuity, taking the form of fetes, carnivals, appeals and sponsored fundraising, as well as staffing hospital transport, running tea-shops, greeting and guiding and organizing gifts and comforts.
- This was the context for Savile's early involvement, which his autobiography records as originating in supporting hospital radio in his DJ days, the expanding into voluntary portering in the 'I'm Backing Britain' campaign of 1967-8.
  - This was a short-lived episode following the Wilson government's devaluation of sterling, when a call was made for workers to voluntarily commit a period of unpaid labour each week to boost the country's productivity; a group of secretaries from Surbiton sparked the campaign by pledging to do this. Following a period of Carnaby-Street hype, in which much Union Jack ephemera and a pop single by Bruce Forsyth was marketed, the campaign fizzled amidst trade union doubts.
- The 'corporate trusteeship' model of charity governance continued during this period, although in the 1970s a few wealthy London hospitals had external 'special trustees' appointed. Only in the 1990s, with hospital trust status established in the internal market reforms, was an alternative model of independent 'appointed trustees'. Moreover, despite its long established regulatory role the Charity Commission did not have significant oversight of NHS charities' management and governance until the mid-1990s, when it

began to ask for formal governing documents for each. In the Savile case, it will be important to establish whether this implied an absence of ethical oversight which might conceivably have counteracted his exploitation of his position. Where the interests of the charity were intertwined with the institutional interest of the hospital board was there a risk that reasonable anxiety about his behavior in the hospital felt by board members may have conflicted with their role as trustees?

## 6. Conclusions

- Recent NHS enquiries into disasters and tragedies have been wary of scapegoating individuals who might have interceded. This is especially the case where 'grotesque', 'rogue' individuals were involved. Examples are Cecil Clothier's 1994 enquiry into Beverley Allitt, the nurse with Munchausen's syndrome by-proxy, who killed and injured children on a pediatric ward with insulin overdoses; and the Chief Medical Officer, Liam Donaldson's, working party report into 'adverse events' in 2000.
  - As Cecil Clothier argued: '... The ancient notion of a scapegoat, to bear the guilt for disastrous happenings and thus relieve feelings of rage and frustration is still with us. ...those we have criticized were subjected by chance to a test more severe than most of us encounter in a lifetime: so we have not striven to find fault merely to satisfy a popular urge...'
  - '... we have been required to examine ... at a level of thoroughness that would have found few institutions, subjected to such scrutiny, without fault or flaw. ...The human mind takes time to grasp a reality that is totally beyond its experience or its comprehension.'
- Instead, such cases illustrate the power of institutional cultures and expectations, and highlight systemic weaknesses
- Hence it is important to consider the cultural and systemic context for Jimmy Savile's exploitation of hospital voluntarism. History shows:

- A long tradition of according status and respect to high profile charitable givers
- Strong, long-term identification of through hospital as symbol of community endeavour through enjoyable social activity
- Long-term acceptance of the place of the volunteer/visitor on hospital premises (though Savile's activities were almost certainly unusual)
- A form of charitable governance in the transition to the NHS which may have created an absence of disinterested/external or ethical oversight