The Patient Contract in Bristol's Voluntary Hospitals, c.1918-1929 [1]

George Campbell Gosling
Oxford Brookes University
(Oxford, UK)

Abstract
The years following the end of the First World War were a time of great change, not least in the field of healthcare. Rising costs and demand ensured that traditional philanthropic sources of income became increasingly insufficient. This necessitated the emergence of new patterns of funding in Britain's voluntary hospitals with a greater place for contributory schemes, direct patient payments and arrangements with the public sector. One aspect of such change was that the largely passive role, in which charitable provision had traditionally held the patient, was called into question. This article places this specific issue within context of the various ideological conceptions of healthcare, each defining the role of the patient in a different way. These are briefly outlined before the local case study of Bristol - and the Bristol Royal Infirmary (hereafter the Infirmary) in particular - is used to consider the impact that changes in voluntary hospital funding had on the role in which the patient was cast (here termed the 'patient contract'). Although there were major changes in funding, most notably the introduction of a patient payment scheme in 1921, the patient contract remained in essence philanthropic. This was the result of a clear ideological commitment, most obviously on the part of the Faculty, to the treatment of the sick poor.

Keywords: Voluntary Hospitals; Philanthropy; Contributory Schemes; Paying Patients.

Introduction

The history of healthcare, as of welfare in general, has been dominated by what Finlayson termed the 'historian of the state' - most commonly adhering to a 'collective train' view of a Whiggish progression toward the final destination of the Welfare State. This perspective has overshadowed the contribution of the voluntary sector.[2] However there has been a recent trend seeking to readdress the balance by considering the history of voluntary sector healthcare specifically.[3] Similarly the interwar period itself was often overlooked, being perceived as merely a stepping stone to the postwar welfare settlement, whereas more recent works have sought to tackle it as a period in its own right, often defined by the mixed economy or experiments in planning and co-ordination. [4] Throughout the 1990s Steven Cherry was an early voice in stressing the pivotal nature of the interwar period in the history of British healthcare, considering the rapidly expanding role of contributory schemes.[5] In the last decade studies looking at this period have likewise often taken an economic angle, most notably the various works of Martin Gorsky, John Mohan, Martin Powell and John Stewart.[6] This study takes its place firmly within this historiographical context in that it is a local study assessing the impact of changing funding patterns in the voluntary hospitals of Bristol during the interwar period.

Bristol's record as a city historically well-endowed with voluntary hospitals, funded by the city's 'wealthy middle class' and 'old urban elite', began in 1737 with the

establishment of the Infirmary.[7] However, after the First World War this tradition of charitable provision was combined with new trends in patient payments, contributory schemes and public funding in what David Owen termed the 'new philanthropy'.[8] The changing role in which this cast the patient, as well as its impact on ideological conceptions of the voluntary hospital sector in Bristol, together form the focus of this study.

Ideologies of Healthcare

By its very nature, the mixed economy in interwar healthcare meant that a variety of ideological cultures co-existed in the healthcare services of the day. Although any categorisation of these is bound to be artificial to some extent, there are some basic trends worth observing. The position of patients within different ideologies of healthcare must be (at least briefly) considered. Three chief categories of healthcare can be defined: those for reward, as philanthropy, and by right. This does not mean that charitable organisations were in practice split into three discrete groups, adhering strictly to differing ideas of voluntary work. 'Human behaviour rarely exhibits such helpful singleness of motive' and different, sometimes contradictory, motivations overlap and co-exist, often even within the individual.[9] However, for the sake of clarity we can consider these approaches as ideologically distinct.

Healthcare, as traditionally provided within the marketplace, has often been characterised as a service that gave the patient a considerable degree of power as a consumer.[10] However, Anne Digby has found that the pre-NHS medical market in General Practice - with methods such as retrospective billing on 'the doctor's individual assessment' - placed the physician in a position of great power, far from the liberating consumerism envisaged by recent advocates and even current government policy.[11] As such, the role of the patient under healthcare for reward is a fickle one, largely determined by an individual's ability to pay.

Similarly, philanthropy is defined not by the passive recipient but by the donor and the volunteer, who decide the timing, scale, method and object of charity. The history of philanthropy has reflected this in a series of attempts to understand the motives behind charitable activity. Social stability was the paternalistic objective for Dr. Barnardo, who declared 'every boy rescued from the gutter' to be 'one dangerous man the less'.[12] Frank Prochaska identified a resistance to the 'sinister' increasing role of the state in the early twentieth century and a fear of 'the bogey of godless Russian communism' in addition to a genuine altruism:[13]

> At the level of human contact, in often tragic circumstances, the idea that philanthropy can be reduced to a form of middle-class social control, unresponsive to the genuine grievances of the poor, is not only inadequate but insensitive.[14]

Meanwhile, social control by means of 'reciprocity' has often been identified with charity, not least by sociologist Marcel Mauss.[15] Alan Kidd has identified the dependency and inequality intrinsic to this 'gift relationship' of charity:

> The dependence of the recipient upon the gift and the consequent inability to reciprocate (or rather to anticipate the possibility of reciprocating) is unlikely to foster solidarity, but rather to reinforce divisions and even to generate resentment. The recipient becomes a material and moral debtor of the donor … we know that charity itself has the power to wound.[16]

As a result, the patient is essentially passive under healthcare as philanthropy.

Whilst charitable provision essentially perceives healthcare as a good deed, the twentieth century witnessed the emergence of a new ideological view of healthcare as a universal right, in line with Finlayson's notion of 'citizenship by entitlement'.[17] There have been various ways this concept of healthcare has been put into practice. For example, S. Thompson sees in the 'medical aid societies' movement as an attempt to provide 'comprehensive public services'.[18] Meanwhile, where eligibility by payment is a form of 'citizenship of contribution', contributory schemes have sometimes been a means of ensuring what *should* have been guaranteed by right.[19] However, this view of healthcare is most closely associated with state provision and figures such as Aneurin Bevan, who argued that '[t]he field in which the claims of individual commercialism come into most immediate conflict with reputable notions of social values is that of health'.[20] Yet whether in the public or voluntary sector, the ideological conception of healthcare available to the whole community by right was increasingly central in the early twentieth century.

Ideology of the Infirmary

In 1735 the Infirmary was founded according to the following manifesto:

> Whereas many sick persons languish and die miserably for want of necessaries who are not entitled to parochial relief, and whereas amongst them who do not receive parochial relief, many suffer extremely, and are sometimes lost partly for want of accommodation and proper medicines in their own houses, and lodgings (the closeness and unwholesomeness of which is sometimes one great cause of their sickness), partly by imprudent laying out what is allowed, and by the ignorance or ill-management of those about them – we whose names are underwritten (in obedience to the rules of our holy Religion) desiring as far as in us lies to fund some remedy for this great misery of our poor neighbours do subscribe the following sums of money, to be by us continued yearly during pleasure, for the procuring, furnishing and defraying the necessary expense of An Infirmary at Bristol for the benefit of the poor sick, who shall be recommended by any the Subscribers or Benefactors in such manner as the majority of them shall direct.[21]

Fourteen years later, in 1749, the motto 'Charity Universal' was adopted.[22] They each tell us a great deal about the motivation for undertaking such an endeavour as opening the second provincial hospital in England.[23] Concern for the well-being of others and identification with the term 'charity' - with its connotations of 'love of God and fellow men, [and] kindness, especially for the poor' - are unsurprising features of an institution initially run largely by the city's Quaker community.[24] Further, in line with the 'liberal

ethos, in which Christianity and commerce neatly joined', 'the city's merchant elite' were the base from which the institution was established and the city's deputy Controller of Customs, John Elbridge, conceived of the idea and became the Infirmary's first treasurer.[25] This tie with the city's wealthy business community remained strong into the interwar period, with the 'plutocratic benevolence' of the industrialist Wills family, most notably H.H. Wills, who was President of the Infirmary from 1917 to 1922 and also heavily involved with the Bristol General Hospital (hereafter the General), making numerous significant donations to both.[26]

Other manifestations of the philanthropic view can be found in the role of donors and volunteers. For example, the subscriber system was adopted, by which a yearly donation of two guineas allowed the subscriber to recommend one inpatient or two outpatients at a time.[27] This cast patients in the aforementioned passive recipient role. At the same time the management and medical staff were all volunteers, executives working unpaid and medical staff 'predominantly honorary'.[28] Their motivation therefore was not directly financial, though in addition to welfare concerns and Christian inspirations, doctors could earn a reputation in voluntary work that would allow for prestigious private practice.[29] However, in the early twentieth century, this traditionally philanthropic approach to healthcare came under threat from a closer relationship with the state and from the increasing prominence of contributory schemes and the introduction of patient payments. These developments weakened the broadly philanthropic ideology of the Infirmary, leaving it between ideologies.

Subscriber recommendations

Whenever an individual engages with an organisation, they do so on particular terms, sometimes agreed explicitly and sometimes implicitly. The terms on which patients engaged with the Infirmary shall here be referred to as the 'patient contract'. During the early twentieth century new models of patient contract emerged, which largely swept away the earlier subscriber recommendation system. The degree to which these new models undermined the philanthropic nature of the patient contract is the issue here.

In her 1921 report, the Infirmary's Almoner commented upon the charitable nature of the patient contract:

> The Bristol Royal Infirmary has been in existence since 1735, as an entirely free Institution and the inhabitants of the City and surrounding district have looked upon it in that light. Charity as represented by voluntary hospitals has become so much part of the established order of things that it is often not regarded as charity at all. It is quite a common occurrence to hear a patient who is receiving free hospital treatment refuse any offer of additional help on the plea that they cannot accept charity.[30]

Treatment was indeed 'entirely free' until the twentieth century, but it was not freely accessible to all. With the exception of emergency cases, admission required a note of recommendation from a subscriber.[31] A 'new channel for paternalism' was provided by the subscriber's right to recommend patients - in the case of the Infirmary this was at a rate of two guineas per year for one in-patient and up to three out-patients at a time,

although in its first century as many as a third of subscribers never made used of this right.[32] The subscriber to whom the patient had to appeal would often be familiar to them through 'residential proximity, employment' or 'religious affiliation'.[33] The subscriber was a powerful figure in this 'gift relationship', a key function of which was to differentiate between those who deserved to become 'patients' and 'the less worthy paupers who resorted to the workhouse'.[34] Further, the recommendation system favoured particular types of patients: for example, those between fifteen and thirty-four were over-represented in the Infirmary and children under-represented.[35]

Over the nineteenth-century the recommendation system became increasingly 'depersonalised', perhaps due to the 'suburbanisation' of society.[36] The system had been considered inappropriate by some, for example at Birmingham Women's Hospital where 'it was deemed undesirable that women should have to explain their condition to anyone but a medical gentleman'.[37] Admission there was decided 'on the basis of clinical need' alone; and similarly Bristol Infirmary's increasingly 'impersonal' admissions saw a rise in the number of patients admitted directly by doctors.[38] Given that it was in the voluntary hospitals that doctors acquired training and experience, the desire to gain such valuable experience for private practice may well have been a motivational factor in treating non-paying patients. Therefore, even without the moral subjectivity of the recommendation, the patient remained in an essentially passive role.

Queen's Hospital in Birmingham chose to abandon the recommendation system in 1876, as did Glasgow's Royal Victoria Infirmary in 1888, both favouring contributory funding and a free access system.[39] Most voluntary hospitals had abolished subscriber recommendations by the 1911 introduction of National Health Insurance.[40] However, alongside Birmingham Infirmary and Guy's Hospital, the Bristol Infirmary resisted this trend and retained the recommendation system 'in the belief that the issue of subscriber's letters was necessary to sustain the enthusiasm of charitable supporters'.[41] It was in the wake of the First World War that the Bristol Infirmary joined the last wave of voluntary hospitals to finally set aside this model of patient contract.[42]

Paying patients

On 21 July 1921 the Infirmary and the General put a new model of patient contract into practice. Under this model admission was essentially a clinical decision, but the patient was then expected to contribute towards the cost of their maintenance. The reasons for introducing such a scheme varied, although there does not appear to have been any great degree of zealotry about moving towards a profit-driven model of healthcare, even from those most actively pressing for the introduction of a payment scheme.[43] Rather, the Faculty was concerned that 'the admission of the cases for payment would give them priority and would thus still further diminish the [accommodation] for the suffering poor.'[44] When five honorary staff members addressed the General Committee, '[t]hey were merely anxious that the long Waiting Lists of Patients should be admitted, it being evident that, at present, this could only be done if some form of payment was received from those who could afford it'.[45] Yet financial motivations were paramount.[46] A 1919 Committee meeting 'unanimously agreed that at present it was impossible to increase the number of free beds at all, and that the provision of paying beds should be considered at once'.[47] A year later the number of beds was restricted to 238, only to be increased if the full cost of the bed could be paid to the Infirmary.[48] The *Bristol Times and Mirror*

reported that 'the important new direction' was one that the hospitals' governors 'have been forced to take', which was 'inevitable if the work were to be continued in any degree according to need'.[49] Certainly it was a time of financial difficulty for the Infirmary. As 1920 drew to a close the Finance Committee was informed that 'the indebtedness of the Infirmary at the present time was £60,000 and that by the end of this year it would probably be increased to £65,000'.[50]

With a broad consensus that patient payments were a financial necessity, the focus soon shifted to the detail of the scheme. A joint sub-committee of the two hospitals met on 10 April 1921 to decide the specifics, where:

> a Resolution was passed that all In-Patients, with the exception of really necessitous cases, should be charged One Guinea per week towards the cost of their maintenance. All … Members present except Mr. Wills voted in favour. [51]

In addition to Wills' isolation on this issue, 'the opposition of the Medical Faculties [rendered it] useless to recommend any exemption or abatement in favour of contributing workpeople'.[52] Two months later the new arrangements, which were to be replicated in December of that year at the Bristol Eye Hospital,[53] were reported by the *Bristol Times and Mirror*:

> (1) In-patients, with the exception of necessitous cases, will be charged 21s. per week towards the cost of their maintenance.
> (2) Out-patients, with the exception of necessitous cases, will be charged a registration fee of 6d. for each attendance, and an additional 6d. for medicine or dressings, etc., when supplied. X-ray, electrical and massage treatment to be charged for specially, according to the cost.
> (3) Insured patients will be required to bring a note from their panel doctor stating that hospital out-patient treatment is necessary, and they will be charged the same rate as other patients.[54]

The emphasis on 'the exception necessitous cases' highlights the expectation of near-universal payment from patients. Yet in reality:

> The contribution is not compulsory and no patient who is financially unable to make a contribution is asked to do so. The scheme … has been carried out in such a considerate way that it does not bear hardly on any patient.[55]

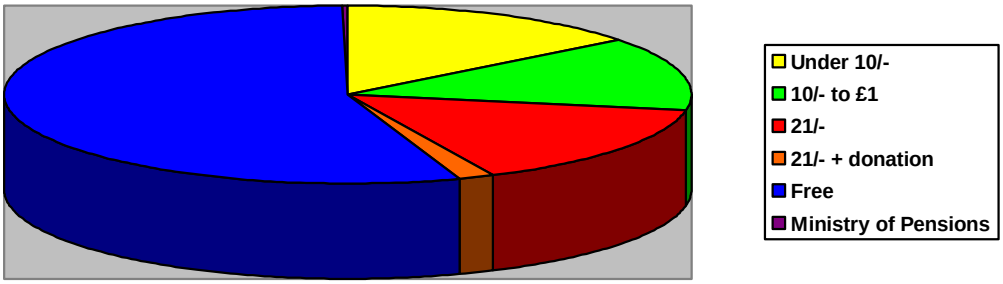
The 'considerate' execution of the scheme was unsurprisingly stressed in this 1921 report which was aimed primarily at donors and potential donors, but it does appear to be accurate: the level of full or partial exemption from contribution was extensive. If universally upheld, the scheme would have generated over £10,000, yet the actual figure was £2,968.[56] While this did more than double the following year, the Almoner's Report notes that the scheme was running for the whole year, while nearly £1,500 came from the approved societies administering the National Health Insurance scheme.[57] The degree of

exemption remained high (see chart A), with only 17% paying the whole guinea and 56% paying no contribution at all. The Almoner explained:

> Both in the in-patient and out-patient departments a very large proportion of cases are passed as entirely free. As long as poverty and unemployment exist this will always be the case and it is well to emphasize the fact.[58]

Year after year the Almoner's reports lamented that '[t]he idea that the contribution was a form of compulsory payment appears to have [been held] widely in the minds of a good many people and cannot be too widely contradicted'.[59]

Chart A Proportion of patients making varying contributions in 1922



Source: Almoner's Report in BRI Annual Report for 1922, p.21.

However, despite public perceptions, the introduction of patient payments did not drastically alter the patient contract. In reality the majority of patients initially paid nothing towards their maintenance and even the one guinea when paid in full covered less than one third of the actual cost.[60] The proportion of patients paying nothing decreased through the 1920s but rose again in the early 1930s, 'due chiefly to the severe depression prevailing amongst the various industries … and unemployment'.[61]

Ultimately, as the Almoner reiterated in her annual reports:

> No patient has ever been refused treatment at the Royal Infirmary on account of inability to make a contribution, [offers having been refused when] the money was needed in the patient's home, or to tide over the period that might intervene between leaving the Infirmary and a return to work.[62]

This was seen in action retrospectively when one patient's payments at 5 shillings per week were refunded after it was brought to the House Committee's attention 'that it was a very great hardship to her to pay anything.'[63]

As part of the patient contract remaining essentially philanthropic, an important distinction was made 'between payment for maintenance and payment of the staff'.[64] On announcing the new contributions, the *Bristol Times and Mirror* explained that:

> These payments, it should be clearly understood, are not for medical services – which will be given gratuitously as hitherto, thanks to the generous spirit of the medical staffs – but solely as a contribution toward the cost of maintenance.[65]

This distinction is significant not because it made any practical difference to the patient, but because it allowed the relationship between patient and doctor to remain a clinical rather than commercial one, despite the changes in the relationship between the patient and the Infirmary. This purely clinical relationship was threatened by the continuing failure of those outside the medical world to recognise this distinction, but it was the purpose of drawing such a distinction in the first place.

The limitation to the universalism of payment in the Infirmary and General scheme was essentially philanthropic. Meanwhile, a different kind of limitation emerged in the similar payment arrangements of the Bristol Royal Hospital for Sick Children and Women: one of geography. The Hospital had never taken notes of recommendation in the belief that, as at the Birmingham Women's Hospital, women ought not to have 'to explain their complaints to anyone but a medical gentleman'. It had previously admitted children up to the age of 13 free and women '*according to their means*'.[66] Under the new arrangements, however, a weekly contribution of 5 shillings was asked for from patients living within a 25 mile radius of Bristol and this was doubled for non-local patients, the burden of patients from South Wales being cited as a factor.[67]

The patient contract at the Infirmary and the General was altered less by the 1921 scheme than by a later and far smaller scheme of 'paying wards'.[68] The 19 patient places in 16 wards charged at £5-5-0 or £8-8-0 for a double or single ward were founded as a step towards payment for medical treatment.[69] Clarification followed that private patients should only be admitted if they could 'pay a reasonable fee to members of staff'.[70] Further, when the issue was raised at a 1928 Faculty meeting, there was unanimous agreement for 'financial recognition of medical services'.[71] However, preference for this 'financial recognition' taking the form of a staff fund, rather than fees paid to the individual doctor, suggests that a relationship between the medical staff and the patient, uncoloured by issues of payment, was still favoured at the Infirmary.[72]

This, of course, depended on the involvement of a third party to deal with matters of payment. The Almoner took care of such matters as arose from the 1921 scheme.[73] However, private patients' medical fees still had to be 'settled by private arrangement with the physician or surgeon in charge of the case.'[74] The Faculty's dissatisfaction with this only abated in 1932 by 'the Secretary's kind offer to collect fees on their behalf.'[75] Such arrangements ensured that even when there was a change in the patient contract, it did not need to alter the relationship between the patient and the medical staff. Given these realities, the fundamentally philanthropic patient contract essentially remained in place despite the introduction of a patient payment scheme in 1921. However, it was somewhat undermined by more limited schemes later in the period.

Contributory schemes

The interwar voluntary hospital sector saw a rapid expansion of medical contributory schemes, which Cherry argues resulted in 'the growth of a quasi-insurance basis to their

activities in place of the earlier philanthropic approach'.[76] Further, Cherry views that such a path ensured financial viability, citing deficits in Bristol hospitals as the consequences of failure to adapt.[77]

Industrial schemes, whereby workers were covered for hospital treatment by their employer, were to be found at the Infirmary, but only on a fairly small scale. That is not to say they did not have a continued existence in the interwar period: the notable cases of two local firms show that they did. In 1919 the annual contribution on behalf of the workers of Messrs W.P. & H.O. Wills was increased from £132 to £300,[78] and in 1921 Messrs J.S. Fry & Sons agreed to pay the first £1-1-0 per week of patient payments for any of their staff.[79] While such examples demonstrate the survival of industrial contributory schemes, even alongside payments, they never provided a substantial fiscal base for Bristol hospitals, as was the case in many other large cities.[80] In fact, where the national average proportion of income derived from contributory schemes more than doubled during the period (from under 20% to over 40%), the Infirmary and the General actually saw a decline.[81]

Any attempt by the Infirmary to independently establish a wider contributory scheme would have been unsustainable given the overlapping nature of Bristol's hospital services - highlighted by numerous amalgamation attempts.[82] In 1925, a regional scheme along the lines of the Sheffield model was agreed in principle by the Committee.[83] Despite agreeing to consider any contributory scheme that the Committee proposed, the Faculty essentially blocked the development on any major scheme by initially refusing to allow exemptions from payments for contributing patients.[84] This could account for the fact that the Bristol Medical Institutions Contributory Scheme (BMICS) never became a 'significant central fund', accounting for only around 3% of income.[85]

In practice, the BMICS suffered from uncertainties over what was covered. As with the 1921 payment scheme, there was a 'mistaken idea among the laity' that medical services were covered, rather than just the cost of maintenance.[86] Further, it was commonly thought that those who had contributed should enjoy a superior service to those who had not, as expressed in a letter from the contributing local firm J.S. Fry & Sons:

> It seems to me that some scheme should be devised whereby those who contribute to the Infirmary Funds should have priority over those who make no contribution.
>
> You will appreciate that it seems to bear very hardly on those who for months, perhaps years, contribute to the upkeep of the Infirmary, that they should be unable to obtain the necessary attention when they meet with an accident.[87]

Such ideas ran contrary to the notion of a universal standard of treatment, with only medical distinctions made between patients, in which the Faculty placed so much importance.[88] As a result, the Faculty found itself, in 1923, 'unable to meet the suggestion of the Gloucester Royal Infirmary' to introduce a dual-exemption from charges for those participating in workpeople's contributory schemes at either hospital, on the grounds that 'preferential treatment is not given to any patients at the Bristol Royal Infirmary.'[89] However, the Infirmary was also committed to not asking any patient for more than one guinea in a week, and this was gradually understood to include those

payments made into contributory schemes.[90] Although clearly the Faculty had difficulties of an ideological nature with contributory schemes, it would be wrong to suggest such ideas were therefore shied away from. For example, following the inception of the BMICS, the Faculty was the source of the idea for an additional scheme to cover those with yearly incomes between £300 and £400, marginally over the inclusion threshold.[91]

In line with Cherry's findings, contributory schemes at the Infirmary, as generally in Bristol, were essentially a failure, undoubtedly contributing to the financial troubles of the period. What should also be noted is that opposition to the contributory model advocated by Cherry was primarily born out of a desire to maintain a traditional relationship between patient and doctor.

Panel patients and public bodies

The early twentieth century saw the public and voluntary sectors drifting ever closer,[92] producing a series of new arrangements in which the patient contract had to be renegotiated. The 1911 National Health Insurance scheme provided the general practitioner services of one of the local 'panel doctors', for workers under a certain income threshold. Despite paying into a compulsory medical insurance scheme, access to hospital treatment for patients under the scheme, despite tuberculosis sanatoria treatment, was highly uncertain.[93] The charge is often levied that panel patients received a 'second-class' service from their General Practitioner.[94] From the case of the Bristol Infirmary it is clear that, despite the Faculty's stated commitment to a universal standard of treatment,[95] they were indeed second-class patients. This can be seen by arrangements where their panel doctor could send them with a note to the Infirmary as an out-patient, but the Infirmary had no obligation to treat them. In reality the honorary staff sought to limit their role to a 'consultative' one. Further, panel patients were subject to shorter out-patient hours and had no right to dressings or drugs, which included a frequently reiterated moratorium on insulin.[96]

During and after the First World War, the state often turned to the voluntary hospitals to meet their increasing obligations to the health of the population. The Bristol Infirmary engaged in such arrangements, most notably in the King Edward VII Memorial Wing taking on the role of the headquarters of the wartime Southern General No.2.[97] However there was considerable hostility from the Faculty over the Infirmary's relationship with the public sector, insisting in 1918, for example, that patients sent by the Ministry of Munitions:

> should not be admitted for payment, but only under the ordinary rules of the Infirmary; especially as, in the present juncture the admission of these cases for payment would give them priority & thus would still further diminish the accommodation for the suffering poor.[98]

Out of concern for patients from public bodies taking priority over the sick poor, the Faculty insisted that admission be conditional: that it must not encroach on the provision for those who could not contribute or could only pay the cost of maintenance.[99] This effectively made second-class patients of those from public bodies, inadvertently undermining the notion of a universal service. In February 1919, 300 military patients

refused to evacuate their beds to make way for a venereal disease clinic for the Bristol Corporation; as a response to which a cap of 200 military patients was proposed.[100] The War Pensioners suffered from both the arrangements of other patient groups taking priority over their own and the inherent insecurity of those arrangements. Tropical and ophthalmic disease patients, whose admission was on grounds of Ministry of Pensions funding, found themselves in a similar situation when the Infirmary threatened to halt their treatment from 1 January 1921 unless the grant was increased.[101] In both cases, patients admitted by agreement with a public body, as those sent by a panel doctor, were relegated to a second-class status at the Infirmary.

Conclusion

The years following the end of the First World War saw significant change in the voluntary hospital sector, not least in the widespread diversification of income sources. However, in this time of change a striking degree of cultural and ideological continuity was possible. This is evident from the philanthropic traditionalism that defined the patient contract in Bristol's voluntary hospitals. This is not to suggest that this was the case nationwide. This local study does not aim to demonstrate that the ideological repositionings previously identified were intrinsic to the period, but rather that they were subject to significant local variability.

A 'quasi-insurance' model for modernisation has been suggested by Cherry as the only means to avoid the financial troubles associated with the interwar period.[102] Such a solution could be described as achieving 'financial health' at the cost of an 'ideological deficit'.[103] This was never a credible option for Bristol, given the late and minimal role played by contributory schemes in the funding of local hospital provision.[104] However, contributory insurance schemes only account for one aspect in the period's diversification in voluntary hospital funding,[105] and ideological repositioning within the voluntary sector was possible. A move towards healthcare for reward could easily have been a reality with the introduction of patient payments in 1921 if it were not for the efforts made, primarily on the part of the honorary staffs, to ensure that access was not determined by ability to pay. Likewise, the continuing commitment to the 'sick poor' was an ideological obstacle in the path of a cultural shift to accepting healthcare as a universal right.

The voluntary hospitals of Bristol did not adopt a 'quasi-insurance' direction. The reason for this was strong ideological opposition rather than a lack of financial necessity. Although the Infirmary was in a stronger position than other hospitals in Bristol, its finances were never a cause for optimism, with the Infirmary's bank overdraft spiralling to over £40,000 in 1920 and higher again to reach £91,000 by the end of 1930.[106] In response, there were temporary solutions such as the sale of stocks and an 'economy on drugs' and more wholesale attempts to modernise - including new methods of funding.[107] Ultimately, however, such attempts were frustrated by staunchly traditionalist elements in the Infirmary who were not prepared to abandon the principle of 'charity universal', which in reality was always more a commitment to treating the city's sick poor, upon which the Infirmary was founded.[108]

The patient contract might indeed have changed beyond recognition, becoming essentially a commercial agreement, but that also did not happen. Although patient payments were introduced in 1921, extensive exemptions ensured that the terms of admission were primarily medical.[109] While this was a change from the subscriber system,

which could be subject to a myriad of motivations, with its distinction between paying towards the cost of maintenance and medical fees, it was hardly the move to treatment on condition of payment that it was widely perceived to be.[110] Meanwhile, the collection of fees by a third party masked the fundamentally altered nature of the relationship under private provision introduced later in the decade.[111] It was such traditionalist sensibilities that ensured in a time of great change that the patient contract did not become a commercial one and that Bristol's voluntary hospitals did not move into healthcare for profit, but rather maintained its philanthropic commitment to treating the sick poor.

Endnotes

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[2] G. Finlayson, *Citizen, State, and Social Welfare in Britain 1830-1990* (Oxford, 1994), pp.11, 3 & 17 See R. Titmuss, *Problems of Social Policy* (London, 1950); T.H. Marshall, *Citizenship and Social Class* (Cambridge, 1950); B. Abel-Smith, *The Hospitals 1800-1948* (London, 1964); R. Pinker, *English Hospital Statistics 1861-1938* (London, 1966); D. Fraser, *The evolution of the British welfare state* (London, 1973).
[3] See S. Cherry, 'Before the National Health Service: financing the voluntary hospitals, 1900-1939', *Economic History Review*, L, 2 (1997), 305-326; F. Prochaska, *Philanthropy and the Hospitals of London: The King's Fund 1897-1990* (Oxford, 1992); M. Gorsky, J. Mohan and M. Powell, 'The financial health of voluntary hospitals in interwar Britain', *Economic History Review*, LV, 3 (2002), 533-557.
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