Eggs, rags and whist drives: popular munificence and the development of provincial medical voluntarism between the wars

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Abstract

Drawing on hospital reports, committee minutes and the local press, this article examines the changing landscape of urban civic culture and challenges the pessimistic accounts of charitable financial support for voluntary hospitals in inter-war England. Through case studies of hospitals in four of the largest cities in the country, it assesses the extent to which voluntary resources of time and money continued to underpin day-to-day institutional income, stimulate the development of the hospitals’ estates and investments, and enable hospitals to cut costs through the receipt of gifts in kind. It argues that by broadening the bases of charitable income, hospitals were freed from their dependence on the wealthy thus ensuring their transformation to modern community resources for all.

Any welfare history that focuses on the transition from the ‘active citizen’ to the ‘active state’ needs, as Finlayson rightly notes, to take into account the many ways in which ‘past traditions survive and influence what comes after them’. Yet by the end of the nineteenth century the rhetoric and practice of philanthropy as an expression of urban civic attachment was supposedly losing its appeal. Local association, and a sense of localism itself, arguably succumbed to a homogeneous national middle-class identity, which was in many ways anti-local and anti-working class. Cities in this rendition became essentially working-class spaces, bereft of middle-class influence, marking the beginning of the end of ‘a once vibrant urban culture’.

However, recent studies have suggested that such disengagement has been significantly overstated. Nor was there any financial falling off of philanthropic endeavour after 1918. As one investigator recorded, voluntary organizations exhibited ‘extraordinary powers of survival’, being remarkably inventive and tenacious in meeting new and existing needs. Excluding religious bodies, the voluntary hospitals were the most important of these organizations before 1939, measured by income and contributing base. Providing the mainstay of surgical and medical hospital provision for working people before the service was nationalized in 1948, they acted, too, as a focus for civic pride, strongly identified with their locality, ‘quasi civic institutions to which all classes could contribute’. Yet what constituted an active contribution remains contentious. Most people, it is argued, did little...
beyond giving ‘tuppence’ per week to their local mutualist hospital fund to obtain cover for themselves and their families.\textsuperscript{10} Indeed, Steven Cherry suggests that the very success of such schemes not only marked the end to ‘philanthropic approaches to the sick poor’ but that those hospitals that did not move quickly to adopt systems of patient pre-payment were the ones most likely subsequently to be running heavy deficits.\textsuperscript{11}

It is certainly true that voluntary hospitals no longer treated only the ‘sick poor’, whose costs had been met traditionally through the charity of the better off. Instead they became key community resources: iconic spaces of technology and knowledge where access to treatment was significantly more open. Such changes of purpose seemingly placed hospital costs beyond the reach of traditional subscriptions, donations and legacies alone.\textsuperscript{12} Yet charitable income remained of considerable importance to hospital finances before 1939. How important, and the degree to which evolving philanthropic activity remained vital, dynamic and increasingly socially inclusive, is the focus of this study of five major provincial hospitals located in the midlands and the north of England.

Notions of decline are based predominantly on aggregated national data drawn from the pages of \textit{Burdett's} and the \textit{Hospitals Yearbook}.\textsuperscript{13} Our approach differs by offering an analysis based on localized institutional records and knowledge to provide a richly textured assessment of the contributions that voluntary action made to the growth of voluntary hospitals between the wars. Philanthropy, it will be argued, became less dependent on elite contributions and much more located in those processes and activities where all members of society were encouraged to contribute time and money to generate common public resources. Thus extended, voluntary activity was not only significant in meeting everyday running costs but was particularly important to funding capital expansion and increasing hospital wealth. Such income is largely disregarded in the pessimistic assessments of the vitality of voluntary giving. Indeed, in many ways the full scale of community voluntary contribution, either financially or in kind, has remained hidden or wrongly ascribed. Thus, this article will examine three areas to assess the importance of voluntary income to inter-war hospitals: the balance between charitable sources and patient payment in the ordinary income of the hospitals; the part played by large-scale appeals, gifts and endowments in growing the capital base of the institutions; and the under-recorded contribution from gifts in kind. Underpinning these broad themes will be an assessment of the growth in popular giving of money and time and a consideration of the possibility that, far from patient payment saving the voluntary hospital system, in some cases, by engendering a weakening of voluntary activity, it placed hospital finances in jeopardy and curtailed expansion.

What then was the structure of hospital provision before 1939? Outside private medicine it fell into two basic categories. The first consisted of what might be called public hospitals. Most had originally been built as Poor Law infirmaries, although by 1938 around half of these had passed into local authority control. Such hospitals provided some 60 per cent of the total number of beds, noticeably for the elderly and chronic sick, in England and Wales. Although significant improvements had been made generally, standards varied markedly. Most, too, lacked the cachet of their voluntary counterparts, being less well equipped and still carrying an inherited Poor Law stigma.\textsuperscript{14} By contrast, the voluntary sector, particularly the larger general hospitals, specialized in acute medicine, A. & E. and outpatient services.
As Abel-Smith notes, the ‘remarkable growth’ of voluntary hospitals after 1919 gave a certain ‘confidence to all those associated with them’. Demand for their services had expanded rapidly. In 1918 English provincial voluntary hospitals treated some 235,000 new inpatients. By 1938 that number had rocketed to 875,000 (or roughly 12½ per cent more new admissions than entered the public hospital sector). Outpatient numbers were also four times higher by 1938 than in 1919. Bed numbers rose substantially. At the end of the war, provincial voluntary hospitals offered 36,400 beds; by 1938 that number had risen to 59,000. It has been noted, too, that over time this expansion led to a greater equality of provision between geographic areas, although noticeable inequalities still remained between need and voluntary hospital provision by 1938. There was also significant investment in upgrading hospital buildings and facilities as advances in medical technology underpinned the widespread introduction of X-ray machinery, improved operating theatres and pathology laboratories.

The five hospitals under scrutiny were each major centres of medicine, yet in terms of the ways money was raised, the parameters of expansion and the channels through which they connected with their local communities, their experiences proved very different. The Leeds General Infirmary (583 beds) was the second largest provincial hospital in England and Wales. It and Sheffield’s Royal Infirmary (476 beds) and Royal Hospital (370 beds) were teaching hospitals. Although lacking a medical school, the Leicester Royal Infirmary (481 beds) and the Nottingham General Hospital (432 beds) matched them in size. Together these five hospitals accounted for 1,746 beds in 1921. By 1938 this total had risen by 34 per cent to 2,342, although their rate of growth was disparate. The Leeds Infirmary, which only belatedly sought to expand its provision, added less than 10 per cent to its bed stock by 1938, while the smaller Leicester Royal and Sheffield Royal Hospital both grew by about 60 per cent across the two decades. Bed numbers in the Nottingham General and Sheffield Royal Infirmary rose by some 30 per cent. Expansion brought other additional capital demands. Leicester and Nottingham each spent around £85,000 on new nurses’ accommodation alone between 1918 and 1938. For Leeds and the Sheffield Royal Infirmary it was significantly less, amounting to around half this figure. Across all five individual hospitals the regression line for bed utilization rose slightly across the two decades, although there was no readily discernible pattern relating this to the broader economic conditions prevailing in each city or to individual hospital finances. Thus, by the mid to later nineteen-thirties bed utilization stood at around 88 per cent (± 2 per cent), and although it fell briefly in Leicester, following the opening of temporary ward accommodation, here, as elsewhere, surplus capacity was quickly consumed. Within this, the ability to treat rising numbers of inpatients varied markedly between these hospitals. The expansion in numbers admitted in Leicester was roughly double that at Leeds and the Sheffield Infirmary 1919–38, and triple that of the Sheffield Hospital. Nottingham lay between these extremes, with patient numbers expanding 50 per cent more quickly than, for example, was the case in Leeds.

Such wide disparities suggest that expansion was determined by a voluntary ability to provide – underpinned by the past and present socio-medical culture of the locality – as much as it was a product of economic circumstance. Nevertheless, the economic challenges faced by our sample cities across the troubled inter-war years were very different.
Leicester and Nottingham were located in the economically more prosperous east midlands, where the greater mix of industries that depended largely on the domestic consumer shielded them from the worst of the economic uncertainties. In these cities unemployment was relatively low, averaging between 5 and 10 per cent in normal years. It peaked in both cities in 1932, with figures of 16,000 in Leicester and 19,500 in Nottingham, or around 17 per cent of insured workers. Thus, pre-slump Nottingham was a ‘prosperous city’, and by 1936 it was ‘relatively prosperous’ again. National investigators found Leicester to have the ‘most prosperous air about it of any of the places we visited’, with a ‘rich business population so much in evidence’. Yet even here it was accepted that ‘trade conditions constitute an important factor in the welfare of voluntary hospitals’. Sheffield, by contrast, remained heavily dependent on steelmaking, an industry which stumbled from one economic crisis to another after 1918. Unemployment never fell below 14 per cent, and in the crisis years following the war, and in the early thirties, it was more than double this, totalling 56,000 in 1932. Hospital managers lamented the impact of poor trade on their ability to raise funds, it being a constant refrain of hope that ‘the present year will bring in its path increased trade and prosperity to the heavy industries, with greater financial support for the Institution’. Leeds sat somewhere between these two urban extremes. Its traditional sectors of textiles, engineering and coal fared badly – unemployment reaching 38,000 – but as in Nottingham and Leicester female employment in areas like ready-made clothing expanded, underpinned by a wider commercial and retail sector than in Sheffield.

Setting to one side, temporarily, the likely impact of variable trade conditions on each hospital’s ability to raise income, a number of authors have also drawn attention to the general diminishing importance of ‘traditional charity’ to voluntary hospitals after 1918. Philanthropy, it is argued, was being ‘squeezed by shifts in public choice, in favour of municipal provision on the one hand and mutualist [contributory] and commercial arrangements on the other’, all of which obviated the need for charity in the eyes of donors. However, not all have taken such a pessimistic view of voluntary vitality. As Finlayson rightly notes, voluntarism ‘remained of considerable importance in terms of both the ideology which it embodied and the methods of implementation on which it relied’. Even critics accept that there was no widespread ideological conversion away from voluntarism to state-provided medicine before 1939, that charitable giving remained significant, and that decline was muted by an expansion of new forms of fundraising from a broader social constituency. Yet this is often dismissed as insignificant in the face of the juggernaut of patient payment.

Table 1 identifies the origins of moneys paid into the maintenance accounts of our five hospitals, divided broadly between philanthropic/voluntarist sources (subscriptions, legacies, donations, collections, gifts and income from investments), on the one hand, and the various types of direct and mutualist worker payment systems, on the other. Clearly there existed a significant range of experience, captured by the scale of giving and the changing balance between philanthropic income and payments for treatment, with Nottingham and Leicester standing in sharp contrast to Sheffield. One explanation, perhaps, was that rising patient payments accelerated philanthropic decline, if only because workplace donations and subscriptions would be converted into payments to work-based Saturday and contributory funds. Thus, at the Sheffield Royal Hospital, the subscriber income in 1921 amounted to
£2,852 of which £1,420, or about 50 per cent, came from works and working men’s contributions. By 1926 the figure from subscriptions had fallen to £1,543, just over half the 1921 figure, almost all of the works contributors having switched to the Penny in the Pound mutualist contributory scheme. In one sense, then, this was the same voluntarist money residing under a new pre-payment label. Yet in Leicester, where some 60 per cent of subscriptions and donations were workplace based and only around a third came from private individuals in 1919, voluntarist income held up, as the hospital found new ways of attracting such funding. The scale of expansion of the hospital Saturday funds also varied considerably. In 1919 they raised some £17,000–£20,000 each in Leeds, Leicester and Nottingham, whereas in the two hospitals in Sheffield they raised only £13,000 between them. By 1938 the total raised collectively across the five hospitals had more than tripled, amounting to over £235,000. Leeds, Leicester and Nottingham between them raised £120,000, or roughly double the figure twenty years before, but in Sheffield, where the most sophisticated scheme had been developed, totals had risen nine-fold to stand at £116,000 p.a.

Such funds were seen as both charity and insurance by their contributors. Members wanted a statement of benefits, but supporting the hospital, and self and mutual help were also thought to be important. Significant, too, was that local contexts differed markedly. Cherry has suggested that there was an inherited dislike within Sheffield’s labour movement of medical voluntarism and traditional Saturday Fund activity. Arguably, it took the formation in 1922 of an integrated contributory fund offering hospital, home nursing and convalescent services to overcome such resistance. In Leeds, the independent Workpeople’s Hospital Fund adopted a contributory system in 1930. Leicester and Nottingham, however, held true to the earlier principles of Saturday Fund voluntarism, where a weekly payment of two or three pence brought collective recommender rights for in- and outpatient treatment, rather than the de facto medical insurance which came with contributory fund membership. Nottingham, the smallest scheme, finally converted to a contributory principle in 1938, although even then it was a contentious decision, splitting the hospital board and fund membership, having already caused much recrimination and bitterness. Leicester never converted. It had no need to, it argued, because the existing scheme was already successful. By 1938 it was still one of the largest funds in the country, collecting £63,500 annually, of which £44,000 came to the Infirmary.

Certainly a negative correlation existed between rising contributory income and a falling off in subscriptions, donations and collections. Yet across all our hospitals, excepting Sheffield Infirmary, when measured at constant prices total charitable income was still higher in the final quarter of the period than it had been in the first (Table 1). But the mode and source of this giving was altering, as was the rate of change across the five hospitals. If generally middle-class contributions through subscriptions and church and associational donations were declining, they were being replaced by community-based activities like galas, dances and other fundraising events which were not functionally tied to notions of a medical ‘reward’, or to individual altruism or prestige. Rather, they represented a growing collective commitment to support institutions seen as being owned by the public. In Nottingham, for example, the amount raised by entertainments each year between 1919–23...
and 1934–8 tripled in real terms, so that by the last quarter it was accounting for over 20 per cent of charitable income (outside interest and legacies), or on average some £4,600 p.a. But again the range of experience was different. In Nottingham charitable income grew as a percentage of rising total income, in Leicester it held steady, while in Leeds it fell when the rapid increase in payments income diminished its proportional significance. Only in Sheffield did we see a decline in cash terms across the whole period and this was minimal.

However, even here the numbers can be deceiving. The 25 per cent employer contribution to the Sheffield Penny in the Pound scheme effectively re-categorized a significant proportion of middle-class benevolence, so that while subscriber income at both Sheffield hospitals fell by almost half between 1921 and 1926 this was because, as already noted, most works contributors switched their mechanism of giving. It was, effectively, and once again, the same money going into a differently labelled pot. Thus, iron and steel employers alone were contributing over £4,000 p.a. to the contributory scheme by 1924. In Leeds, by contrast, a number of employers continued to contribute through the subscription lists. These were mostly businesses located some distance from Leeds or with head offices in other towns, such as the Co-operative Wholesale Society (C.W.S.), with its base in Manchester; the big railway companies, London Midland Scottish (L.M.S.), which gave £400, and London and North-Eastern (L.N.E.R.) £150; other local co-operative societies such as those in Barnsley, Cleckheaton and Ossett; and breweries like John Smith’s of Tadcaster. The collieries were another important group of corporate givers who sat outside the Leeds Workpeople’s Hospital Fund (L.W.H.F.), Airedale Colliery at Castleford subscribing £100, Waterloo Main in Pontefract giving £36 and the East Ardley Collieries in Wakefield £25. Present, too, were council departments, friendly societies and workers’ funds not affiliated to the L.W.H.F. In total these 430 corporate subscriptions, whether business, mutual or charitable, accounted for £3,600 of the £5,600 subscription income in 1938.

Yet, as distinct from Sheffield, over half of the Leeds General Infirmary subscribers were still private individuals, the numbers holding up surprisingly well. Thus, in 1919 the 1,300 subscribers comprised 750 ‘corporate’ and 550 individual givers, while twenty years later – as in Nottingham and Leicester – members of the old elite continued to give up to £50 p.a., although most of the 500 individuals subscribed the traditional one or two guineas. Moreover, these men and women were supported by others who gave through the various employer and self-employed funds, who contributed to Hospital Sunday, gave donations (which rose during the period) or contributed to one of the city’s other four specialist voluntary hospitals. Thus, wealthy Jews tended to support the Herzl Moser Jewish Hospital, women contributed to the Maternity Hospital and to a lesser extent the Hospital for Women, while clothing manufacturers were particularly involved with the Public Dispensary. In Nottingham, on the other hand, subscription levels rose from £4,500 to £11,300 from 1919 to 1938. Yet in Sheffield the formation of an active contributory fund saw donation levels plummet. By 1923 total income from this source at the city’s Royal Hospital had fallen to only £2,210, or 40 per cent of its high two years previously. Already there were very few individual donations: just 50 people gave £10 or less. Contrast that with Leicester, where donations rose from £6,000 to £11,400 across the period.
Clearly, the trends within each income stream offer a particular insight into the activities and changing socio-medical cultures within each city. This particularly needs to be placed in context, especially in relation to the contention that voluntary income was being replaced by systems of patient pre- and direct payment. The most comprehensive study of provincial hospital income across the inter-war years, by Gorsky and others, is based on aggregated data taken from the *Hospitals Yearbook* across a range of sixty-three general hospitals. It emphasizes both the diminishing significance of traditional charity as a proportion of total hospital income and, measured in real terms, a fall in annual money value by the mid nineteen-thirties, signalling a ‘decisive turning, when philanthropy, already a junior partner in the funding mix, then went into decline’. ¹⁵² Notwithstanding this, the authors also note here and elsewhere that ‘the particular funding mix varied from place to place, between regions and hospital types’ and acknowledge that income from charitable sources was ‘by no means defunct in the late 1930s’.¹⁵³

The degree of variance between hospitals, however, remains largely unspecified in other than general terms, the detail being lost in the aggregated figures. In fact, the differences were stark and remained undiminished. If we take as our starting point the Gorsky sample, then income from traditional charitable sources ranged per bed from an upper to lower decile mark of £92 10s to £35 14s 1d in 1926 (the first year for which comprehensive figures are available from the *Hospitals Yearbook*) and from £85 1s to £33 8s in 1938 (all figures in this section are given at 1928 constant prices).¹⁵⁴ Within this range, our own sample broadly reflects these disparities. In 1926 and 1938, both Sheffield hospitals remained firmly bedded in the lower 10 per cent range, with voluntary incomes constant at around £28 to £31 per bed. The position in Leicester and Nottingham was very different. In 1926, although both stood outside the top 10 per cent of voluntarist earners, each still derived a charitable income of £89 4s and £70 12s per bed respectively. By 1938, voluntary income at these institutions had risen to £99 18s and £87 6s, placing each comfortably in the highest 10 per cent of generators of such moneys, with Leicester actually topping the listings. Leeds’s ranking position also improved across time. In 1926 its charitable income stood at about £63 12s per bed. By 1938, voluntary income had risen slightly to £65 10s, compared to an average fall per bed across the whole sample of some 13 per cent. Averaging and aggregating figures obscures other noticeable trends. In the broader sample, for example, while certain major hospitals (Victoria Infirmary Glasgow, Addenbrookes, Cambridge and the Royal Southampton) witnessed spectacular drops in voluntary income per bed across the thirteen years, by contrast almost half of all hospitals saw voluntary income rise. In 1938 only one of the hospitals ranked above the upper decile mark had occupied that position in 1926, and that trend generally held for above the upper quintile point too, as those hospitals with positive growth saw their charitable incomes per bed rise noticeably by some 17 per cent between 1926 and 1938. Put simply, numbers of hospitals adapted through the inter-war period to raise considerable sums via traditional and neo-traditional mechanisms, and numbers, too, did not. Moreover, more than 60 per cent of those hospitals above the upper decile line in terms of voluntary income raised per bed were correspondingly in the lowest ranking 20 per cent whose money was generated though patient payments.
It is worth questioning why it was that in Nottingham, for example, subscription levels more than tripled in real terms over the twenty-year period. The answer lies in two parts: first, the late conversion of its Saturday Fund into a quasi-insurance-based contributory fund, so that subscribers still retained a voluntarist sense of obligation; and second, the aggressive campaigning by the board and its supporters through a number of clearly defined recruitment campaigns. It is noticeable that a strong correlation existed in Nottingham, and in Leicester, between the mutual expansion of both charitable and Saturday Fund/patient payment, whereas for both Sheffield hospitals the expansion of the latter as a source of income heavily reduced voluntary/charitable revenues. For Leeds the relationship is significantly less obvious. Only when the hospital figures are aggregated does the correlation begin loosely to mimic results in other generalized surveys, falling to levels which are inconsequential in terms of predicting one variable value from the other.55

In terms of aggressive fundraising a major appeal in Nottingham set the pattern for the inter-war years, when some 40,000 targeted letters were sent out immediately after the war to increase donation and subscription levels, the results of which saw increases of 70 per cent and almost 60 per cent respectively as one counter to the hospital’s financial difficulties.56 The appeal was very traditional in its approach, couched in terms of duty and obligation. As the chair of the General Hospital opined, ‘There are many private individuals who might ask themselves the question: “Am I doing what I ought in support of the Hospital?”’, and many employers who might well ask themselves the same question.57 But in this instance, too, it had a particular resonance tied to a public process of wartime memorialization. One constant refrain from all boards was that the wealthier should match the working-class contribution made through the contributory schemes; that not to do this was socially negligent or against their self-interest. The chairman of Leeds Chamber of Commerce commented that employers should look at contributions not as a charitable donation but as one ‘on a par with insurance … Those of us who are in charge of firms who [sic] have machinery know that in the event of a catastrophe happening at any time, the first telephone bell that would ring would be the telephone at the Infirmary’.58 On the other hand, when the Sheffield Joint Hospitals Council attempted to restore subscriptions as part of an overall drive to increase gross income for all the hospitals by £40,000 p.a., their efforts to target various classes of subscriber proved illusory. Despite a large and costly campaign, the two main hospitals secured less than 10 per cent of the proposed new subscription income.59

Of course, these were not the best of economic times. In prosperous Leicester, where giving had raced ahead during the nineteen-twenties, subscriptions and donations fell by some 13 per cent measured peak to trough across the economic cycle (1928–32). Yet generally, in real terms, giving proved remarkably resilient, so that the actual shortfalls were minimal.60 In Nottingham, money from subscriptions and donations actually rose by some 8 per cent, and in Leeds and Sheffield it held fast, although in the latter, as already noted, subscription income had already collapsed following the introduction of the Penny in the Pound scheme. Thus, if institutions were wont to report a fall in ‘philanthropic’ income as being the product of economic uncertainty, in practice outcomes depended more on the perceptions and actualities of organization and commitment.61 Moreover, the impact on their ability to treat patients was also limited. The greatest effect was at Leeds General, where new inpatient
numbers peaked in 1930 at 14,236 then fell by around 8 per cent to 13,083 in 1932. In Sheffield, however, there was little change, new inpatient numbers remaining stable at the Royal Hospital and actually rising by more than 12 per cent at the Royal Infirmary between 1929 (7,481) and 1932 (8,343).62

It was not simply during the period of trade depression that the position in Nottingham was noticeably different from, say, Sheffield. Most significantly a clear majority of subscriptions and donations across the inter-war period came from individuals and not from companies, organizations and associations. The value of subscriptions rose by more than 250 per cent over the two decades, from £4,500 in 1919 to some £12,000 by 1937. Everyday donations also expanded significantly. The majority were relatively small, so that half of the value collected in 1919 came from donations of less than £50.63 The numbers of individual donors doubled in the nineteen-twenties, and had doubled again by 1938. Schemes were also developed to catch the casual giver. The Nottingham General’s secretary was initially dismissive of collection boxes in pubs and workshops, as the return was ‘barely worth the time spent in collecting’.64 But by the mid nineteen-twenties, the hospital had some 300 boxes raising over £600 per year, and by 1939 the number had risen further to some 500, scattered all over the city in clubs, pubs, billiard halls, police stations, banks and other public buildings.65 By the end of our period, donations through boxes raised around £1,800, of which a quarter came from boxes inside the hospital. Similar schemes ran in Leeds, raising around £1,800 in 1929, before declining during the nineteen-thirties, bolstered further by £400 a year from the sale of matchbooks. Yet pub and club collections organized separately by the L.W.H.F. continued to raise a further £6,000 p.a. by the end of the nineteen-thirties, although this was categorized by the hospital as a patient payment, which it most certainly was not.66

The impetus to collect was relentless, albeit not always successful. Nor was collecting a passive activity. Nottingham’s sub-postmasters actively extracted donations from their customers, and the most successful each year was awarded a silver cup.67 Donations from ex-patients, friends and relatives were also encouraged, netting £1,020 from some 800 donors in Nottingham in 1920. By 1939 this had risen to £2,700, although again for accounting purposes this was recorded as a patient payment. Yet when Leicester Infirmary attempted to instigate a city wide door-to-door collection to raise £5,000 to cover immediate shortfalls, results were singularly disappointing. A lady canvasser was duly appointed, but after making 2,700 house calls the sum raised amounted to only £150. More localized, community-based collections paid significantly better dividends. At this time, the parish of Kirby Muxloe, just outside Leicester, raised £370 from house-to-house collections and a summer fete, money put to one side to endow yet another bed at the hospital.68

However, other forms of collective fundraising – again where the community was less the instigator than the passive giver – became less important. In all cities income from church collections fell, reflecting the steady decline in organized religion and its charitable activities, although the drop was not of catastrophic proportions, nor was it ever a major income source.69 In Nottingham the Hospital Saturday Fund’s flag day, held as a church parade in conjunction with local nurses and bands, was initially very successful, but the income dipped markedly as the fund increasingly raised its money directly, so that on
average across the period its flag days generated only a third of the £2,300 p.a. secured in the last years of the war. A similar fate befell hospitals’ Alexandra Rose Days. In Sheffield, for example, in 1932, ‘the entire Nursing Staff devoted their free time throughout the day to the selling of roses between the hours of 6.30 a.m. and 9.30 p.m.’ Yet despite this effort, only a few hundred pounds were raised, it being accepted that ‘the contributors to these funds in previous years are most of them now contributing to the “1d in the £” scheme’. In Leicester, collections in the surrounding villages and towns held up better than those in the city but still fell steadily over time. As the social survey organization Mass-Observation later recorded, the general public became actively hostile to flag days, with almost half disapproving, and a further 20 per cent remaining ambivalent, as charitable dependence proved significantly less popular than other notions of medical voluntarism through community engagement, self-provision and the giving of time.

All voluntary hospitals, Political and Economic Planning reported in 1937, ‘have to waste much time and energy’ on appeals and fundraising. Such work could be ‘trying and arduous’, as the board of Leicester Infirmary acknowledged, when thanking its mainly female volunteers who were responsible for the sale and collection of the floral badges. Yet at the same time the myriad voluntary activities bore witness to the ‘continued vitality’ of the ‘philanthropic traditions of the past to command a powerful community response’. Indeed, to be prepared to ‘waste’ so much time as a community was, in fact, yet another measure of local commitment. Take, for example, Nottingham’s whist shield, organized across a wide network of some eighty committees based around voluntary and work-based associations, towns, villages and clubs. At its peak it raised a full £1,500–£1,600 annually.

‘It would be absurd’, the hospital’s president recorded, ‘to suggest that everyone who bought a flag or sat down to a rubber in the Whist Shield Competition … was a “pious benefactor”, but those who did the work of organising these many movements deserved the title as rightly as any’.

It should be remembered, too, that even fully functioning contributory funds raised significant income through fundraising events. In the early nineteen-twenties, almost 25 per cent of the income of the L.W.H.F. came from ward activities, like fetes, concerts and carnivals and the annual hospital gala – collections in pubs and clubs alone raised £7,700 (see, for example, Figure 1). During the Depression many ward activities were abandoned, while attendances at the gala halved, although by 1938 the collections in pubs and clubs still accounted for almost £6,000 of the fund’s income. Even in Sheffield the Penny in the Pound scheme raised, on average, around £3,000 p.a. from fetes, parades and other ‘special efforts’ organized by the ward and district committees. If these amounts were small compared to the hundreds of thousands of pounds the funds were amassing through contributions by the end of the nineteen-thirties, they nonetheless proved to be of ‘great value in maintaining interest in the work of the hospitals, and in extending the “1d. in the £” Scheme’.

Indeed, a major drawback of existing studies is the distorting emphasis given to the place of workers’ contributory schemes at the expense of a range of other income sources. In particular, the large sums of money entered directly onto the balance sheet (or through other specialized accounts) as gifts, endowments, legacies and proceeds of special appeals are
frequently overlooked or play only a minor role in any analysis, in large part because they cannot be processed using national records. Yet as Braithwaite noted some seventy years ago, the ‘striking feature of hospital finance is the large amount of receipts outside of ordinary income’. Between the mid nineteen-twenties and nineteen-thirties some £22.7 million was paid over to provincial voluntary hospitals outside ordinary income, of which £13.4 million was used to fund new building work and other capital projects. In the five years up to and including 1938, provincial hospitals took in a further £1.4 million per annum for capital projects, although their ambition here was such that they were spending collectively on average £85,000 more each year than they raised. The important point is that the principle source of finance for either current or fixed capital assets remained predominantly charitable. Certainly, most ‘free’ legacies – those with no restrictions on the use of the money – did appear on the maintenance account as extraordinary income, but if circumstances permitted or the legacy was unusually large even these were frequently invested rather than used to meet current expenditure (that is, they by-passed the income account to appear straight on the balance sheet). Indeed, in Sheffield all legacies effectively went immediately to the balance sheet: a total of £140,000 in the case of the Royal Infirmary and £100,000 at the Royal Hospital. This money utilized primarily to pay down bank debt. Robbing Peter to pay Paul in this way meant that in each of the quarters in Table 1 the operating surpluses shown were in reality heavy deficits. In fact, both hospitals remained solvent only because of the large loans made available to them from local banks. This dependency is revealed in Table 2, so while our other hospitals added to their current assets, in Sheffield these declined markedly. Even at the relatively wealthy Leeds Infirmary, the books were only balanced by continuous use of free legacies to meet the operating deficit, despite the desire of the board that such income ideally ‘should either be invested or reserved for special expenditure’.

The interdependency between the maintenance and capital accounts can also be illustrated by examining income generation from investments, primarily as a consequence of endowments. In 1919 at Leeds, Leicester and Nottingham this amounted to between £3,000 and £6,500 annually, not too dissimilar to the Sheffield hospitals, which averaged £3,400 p.a. Twenty years later the former three averaged £14,500, providing between 14 and 16 per cent of ordinary income, whereas in Sheffield investment income hardly rose. Thus, against a national picture of noticeable relative decline as a proportion of ordinary income, in Leicester and Nottingham income derived from investments almost doubled, rising from 9 to 16/17 per cent, whereas in Sheffield it roughly halved as a source of maintenance income. The degree of the disparity can be captured through the trends of growth in current assets (Table 2). Specifically, in 1919 Nottingham General had assets, excluding buildings and equipment, of around £93,000, which rose four-fold to stand at £354,000 by the outbreak of war, a total only a little short of the money raised through ordinary subscriptions and donations. The figures for Leeds and Leicester were equally robust, rising from £130,000 to £386,000 and from £123,000 to £570,000 respectively. In Sheffield, once again the picture was very different. Here productive assets either fell or rose only slightly, so that in terms of investments the Infirmary was £21,400 poorer after twenty years, while the Hospital was only £7,000 richer. Thus, as noted elsewhere, considerable variation existed between hospitals within the voluntary hospital sector, although this should not lead us to
conclude that overall hospital finances across the sector were deteriorating, nor to ignore the continuing and significant contribution made by investment income to many major provincial hospitals. Although the hospitals in Leeds and Sheffield endured year-on-year deficits throughout the nineteen-twenties and Depression, there is evidence to suggest that the balanced budgets which characterized the mid to late nineteen-thirties actually offered the opportunity to bolster investment income and/or embark on new building projects. Thus, at Leeds investments for general purposes rose by 25 per cent between 1934 and 1938, while in Sheffield the Infirmary was able to undertake a range of small building works in the second half of the decade at a cost of £25,000 and the Royal Hospital more than doubled the value of its land, buildings and equipment in the same period. Moreover, the Sheffield hospitals were also able to commit £15,000 each towards the purchase of land and the drawing up of plans for the new amalgamated hospital.

Endowments, which had previously been the preserve of the wealthy to commemorate the death of a close relative or as a personal legacy, increasingly became part of the collective giving by organizations, workplaces and communities which came to characterize the inter-war period. Of the ninety-four £1,000-bed endowments in Nottingham from 1919 to 1938, 40 per cent came from workplace or community-organized donations. In general the number of beds being endowed per year was four to five times higher than in the years before 1914 as the hospital raised local community awareness of its needs. In Leicester the split was similar, although the totals raised were significantly higher, with 144 bed endowments, and a further seventy-one £500 cots endowed. Leeds sat between these two in volume of endowments (130 beds and over fifty cots) but with rather more individual donors. Around a third of the beds and a quarter of the cots were sponsored by business or community groups. Yet once again giving was least common in Sheffield. Together, the two hospitals acquired around fifty £1,000 sponsored beds and twenty £500 cots after 1918, almost all supported by individuals. There were additionally annual payments for five beds and five cots from businesses and organizations like the entertainments charity the ‘Gloops Club’. Unlike the other cities, in Sheffield it appears that few accepted the missive that ‘no more suitable memorial of a deceased relative or friend can be made than by an endowment of a bed or cot’. Such a disparity may have derived from the relatively small activist middle class or the stifling effects on voluntary activity produced by the Penny in the Pound scheme.

Cinema collections in Leicester raised money for seven endowments, and in Leeds for four. Easily the largest single fundraisers in Nottingham, as in Leeds, were the University Students’ Unions, whose yearly rag weeks raised enough to endow eighteen beds in each city across the period. Beds were also endowed by groups of workers and by mutualist organizations like the Nottingham Saturday Fund, the Oddfellows, and miners’ welfare and co-operative societies. Leicester was particularly successful in garnering money from its surrounding areas through local bed endowment committees: for example, the village of Wigston Magna endowed five beds before 1939. Across the city in Sileby in 1921 the village offered to hold an annual Adult School Fancy Dress Parade to raise £1,000 over ten years to endow a bed at the Infirmary. So successful was this event that by 1938 it had had raised five times that amount. Such activities were central to instilling the habit of
communal giving. Collections were held at bespoke concerts and sporting events, and many organizations, especially sport and social clubs and societies, contributed sums on an annual basis to help maintain a bed, including in Leeds two competing amateur dramatic societies, the Amalgamated Society of Anglers and the boys of Leeds Grammar School. As the president of Nottingham’s hospital wryly observed, there were increasingly many forms of mass subscriptions and donations ‘that had been cunningly devised for the diversion of small sums into the coffers of the hospital’. Collectively these small sums added up to thousands of pounds in investment income which complemented the less predictable gifts of the very wealthy.

It was these activities, as much as wealthy bequests, which diversified the income base and thus fuelled growth. This is not to deny, however, that all our hospitals benefited from significant, and many hundreds of less significant, individual gifts and bequests. The largest of these went to the Leicester Royal Infirmary. Henry Mills, a board member and vice-president of the hospital, had, in the nineteen-twenties, already given £20,000 towards the cost of reconstructing a new hospital wing. On his death in 1933, he left a further £120,000 to meet the running costs of the ward named after him. As the Infirmary acknowledged, this did ‘much to restore the financial balance which, particularly in the recent years of commercial depression, has operated against the Institution’. The steel magnate Alfred Bosher left £70,000 to the Sheffield hospitals, which they used to reduce their overdrafts. Jesse Boot gave £50,000 to endow Nottingham General’s convalescent home. And at times of financial illiquidity, or to fund specific appeals, it was common for board members metaphorically to pass the hat around themselves and within their circle.

It was, however, large-scale special appeals – usually linked to events like anniversary ‘celebrations’, memorialization or major modernizing initiatives – that fuelled the growth of the fixed assets. Yet we can see from Table 2 that the patterns of growth were very different, with Leicester and Nottingham expanding continually after 1919, particularly in the early to mid nineteen-twenties, while in Sheffield and Leeds, expansion was both more limited and delayed. The root cause was the financial circumstances prevailing in each hospital, which in turn centred on an ability to mobilize broader support. For example, all five institutions launched major appeals at the end of the First World War but for very different purposes. Sheffield and Leeds needed to clear accumulated debt. Both Sheffield hospitals were able to settle their building fund deficits and make limited in-roads into their substantial bank overdrafts. In Leeds the £27,500 raised, plus a gift of £50,000 from the soap manufacturer Joseph Watson (later Lord Manton), helped briefly to reduce its overdraft, but just five years later a second city-wide appeal was required to clear the collective overdraft of £200,000 across all the city’s hospitals. It secured less than half its target. In both cities almost all this income came from business or wealthy individuals, and very little from community groups or even smaller individual donations.

In Nottingham and Leicester the focus was instead on expansion as a fitting form of memorialization for the war dead. In Nottingham a new nurses’ home was built and a new heating system installed, costing altogether £100,000. There were significant individual donations: tobacco manufacturers John and William Player each gave £10,000, their employees £5,000, and the Red Cross a further £15,000. A little under £7,000 was raised by
the nurses themselves by holding a bazaar. Yet the real key to success lay in the many individuals who each gave £250 and £500. For William Player, the hospital became his life’s work, and something he found immensely pleasurable. He gave lavishly of his time, chairing the building committee and later the monthly board, and of his money, donating in total about £150,000 in regular annual amounts. Eighty per cent of this went to capital building and improvement programmes: a new outpatient and casualty department, several new wards, a physiotherapy unit and X-Ray facilities were all added in the nineteen-twenties. His brother John also gave £25,000 towards meeting the cost of a pay-bed wing.101

As one senior medic noted, Nottingham’s hospital had ‘many powerful, generous and zealous friends’, although ‘it was always the same people who gave’.102

Thus, the Players contributed about 40 per cent of the £370,000 spent on capital projects by 1938. If subsequent appeals were more broadly based – with large sums coming from wireless appeals, whist drives and the like – primarily it remained the local great and good who drove forward expansion and modernization. Community fundraising centred largely on meeting an ever-rising daily expenditure. But there was, too, an enduring tension between specific appeals for special purposes and the need for donations and subscriptions to meet running costs; a fear that one might squeeze out the other. Thus, during the Leeds appeal of 1934 the secretary’s report urged ‘the importance of every effort being concentrated on the Appeal’ to complete the programme of urgently needed improvements, while the chair cautioned against too wholehearted a devotion to the campaign, fearing that subscriptions would fall away.103

Leicester’s initial approach was similar to that in Nottingham. It, too, launched a memorial appeal to provide a new isolation hospital, additional staff accommodation and an orthopaedic department, at a cost of some £30,000. Yet the receipt of a £20,000 bequest, plus large donations from the Red Cross and the Rutland Prisoner of War Committee, caused the board ‘to look to the future rather than the present’, amid ambitious plans to raise a further £100,000 to construct a new wing and significantly increase nurses’ accommodation.104

However, this venture recognized that hospitals were no longer something one part of society ‘gave’ to another but that their support should now be a collective effort. ‘The day is passed’, it was argued, ‘when we can expect a small number of contributors to be responsible for the support of the hospital – rather we must look for contributions spread over the entire community’.105 Thus in renegotiating traditional relationships between the hospital and its community, the 150th anniversary appeal utilized a novel county-wide collection scheme which saw units of contribution based on an individual community’s population and rateable value (that is, its relative wealth). Thus, in rural areas and working- and lower-middle-class communities, four to five households were asked to contribute collectively 12s 6d. The chair of the board gave £10,000 to launch the appeal, and companies and trade associations were asked to contribute according to their size. Villages, streets and individuals came together to meet their quotas, often using set events as a fundraising focus.106 The Infirmary was able to claim it as a great success ‘largely because of the equitable nature of the appeal’, which mobilized many more groups and individuals than conventional fundraisers or similar events in the other cities, with more than one in five households contributing just to this one fundraising event.107
Other appeals were more traditional in terms of targeted donor base. The £50,000 needed to reconstruct Leicester Royal Infirmary’s central wing came primarily from one large donation of £20,000, and some fifteen donations ranging between £1,000 and £3,000 from individuals and companies. Even here, however, the second largest contributor, giving £10,000, was the local Hospital Saturday Fund. Other appeals were less successful. Launched at the height of the economic downturn in 1931, an anniversary appeal for £50,000, where contributors were asked to sponsor a nurses’ bedroom for £60, foundered through the nineteen-thirties, finally closing some £12,000 short of its target. One of the most successful fundraising components, as in Nottingham, was a four-day bazaar organized by the nurses themselves and supported by the Rotary Club, Leicester Industrial Committee (employers and employees) and the Saturday Fund. On its own, through stalls, sales of works, publications, entertainments and sponsorship, this rather tried-and-tested form of fundraising – albeit it with a modern twist that placed ordinary people at its heart – took in £13,275. Noticeably, too, the hospital’s appeal for building funds in the late nineteen-thirties (Figure 2) was greatly aided by substantial grants of £15,000 and £5,000 respectively from its Saturday Fund (paid for by an increase in subscription rates) and from the Leicestershire Miners’ Welfare Fund.

In Sheffield, too, a more populist approach was tried. The Royal Hospital’s centenary appeal committee in 1932 thought ‘few large contributions could be expected owing to the depressed state of the local industries’. Instead, it determined to approach ‘every section of the community with a request that efforts of all descriptions should be started; such as Entertainments, Concerts, Dances, Garden Parties, Collections, and so forth’. The two political parties and the Trades and Labour Council agreed to put their organizations at the disposal of the Hospital to support a house-to-house canvass for donations. Other contributing organizations included the Education Department, unemployed workers, Rotarians and the Boys’ Brigade. A film was made to show the ‘actual work of a hospital’ and an air pageant was put on by the Sheffield Motor Organizations. Despite this the total raised was disappointing – just £21,000.

The appeal did, however, elicit a promise of £25,000 from the South Yorkshire Miners’ Welfare Fund to pay for a new block and the gift of Tapton Court and six acres of land as a nurses’ home from J. C. Graves.

Fundraising in Leeds in the nineteen-thirties similarly targeted everyone and everything to raise the £250,000 needed to fund future expansion. It did this through a rolling programme that mobilized new constituencies across the life-cycle of the appeal, while at the same time securing donations from the wealthy: those families ‘who have for generations given of their best, both in service and money, when an Appeal has been made to them’. In the first year there were thirty personal donations of £1,000 or more, 100 contributions of between £100 and £1,000 and a further 100 of £25–£100, plus substantial company donations. The following year the approach changed markedly, with large numbers of ordinary citizens mobilizing through the ‘very many social and other events held on behalf of the Appeal which have been the means of raising considerable sums’. Eighty per cent of the more than 1,000 separate donations in 1934 were for less than £100, drawn mainly from clubs and associations, many linked to political parties, sporting events, contributions from school...
children and students. In the final phase the Million Shilling Fund aimed for a singularly more socially diffuse approach to fundraising. Twenty-five local committees were formed across Leeds and the surrounding districts and over 1,000 firms signed up to give 2s per week. In all, £32,000 was raised to complete the appeal. The chair of the fund emphasized its democratic nature, noting: ‘With an Appeal of this size one would normally expect something like 5,000 donors; the number on our list is 60,000’. 115

The most ambitious campaign, however, was the Sheffield Voluntary Hospitals’ Million Pound Appeal that followed the amalgamation of the Hospital and Infirmary in 1938. It sought funds for five building projects, including a pay-bed block at the maternity hospital, cancer research laboratories and, most notably, a new general hospital (Figure 3). It was based on a tripartite appeal to all sections. ‘It is not healthy’, the appeal launch argued, ‘for any community to depend on one or two benefactors to provide the necessary money for its Hospitals; it is the duty of the community as a whole – it is YOUR responsibility’. 116 Thus, the Ministry of Health was informed that ‘The majority of local Firms are co-operating, subscribing fifty thousand pounds per annum for seven years’. Similarly, the 250,000 subscribers to the ‘Penny in the Pound’ scheme were to be asked to give a further penny per week. The final third of the money was to be raised through private subscription. Included here were several local authorities, from whom substantial support was expected. 117 By the time the appeal closed in 1947, a staggering £500,000 had been raised, much of this collected after 1942 at a time when the very future of voluntary provision was in doubt. The bulk of the money came from worker subscriptions, but there was a sizeable contribution from both business and private individuals, Graves once more stepping in to provide £100,000 for the Radium Centre. 118 Thus, in Sheffield, which had generally found it difficult to raise money for expansion by appeals and fundraisers, salvation came through a bureaucratic scheme which drew heavily on the existing Penny in the Pound arrangement, with only limited input from traditional charitable sources and techniques. The willingly given additional voluntary contribution by scheme members suggests that they did view their membership as more than simply insurance; however, they had become accustomed to ‘giving’ in this manner rather than through ad hoc activities as we have found elsewhere.

A third key source of support for inter-war hospitals rarely appeared in the accounts and has been largely overlooked by historians. It consisted of a wide range of gifts in kind which reduced outgoings, increased assets and improved the experience of patients and staff. Such gifts drew on the full range of potential donors from the wealthy philanthropist to the village schoolchild, and serve to encapsulate the persistent and increasingly democratic ‘hospital spirit’. There were two main types of gifts – the useful and those aimed at the comfort and enjoyment of patients and staff. The development of Tapton Hall, Sheffield, as a nurses’ home, for example, was underpinned by additional gifts in kind, including a grand piano, furniture, fireplaces and curtains from the wealthy, while the unemployed men from the Rodney Hill Allotment Society ‘kindly gave their services in helping to recondition the gardens and grounds’. 119 In a similar vein, the treasurer of Leeds General Infirmary T. F. Braime oversaw the redevelopment of the workshops at the Infirmary, calling on a wide range of local firms to provide materials, equipment and even labour for free. 120 All institutions benefited, to a lesser or greater extent, from the growth of corporate giving by
national and local companies. These included the British Oxygen Company’s free provision of all the oxygen required by both of the Sheffield hospitals, free disinfectant from the makers of Izal, occasional gifts of jam from Robertsons, and tinned vegetables from Batchelors. Local suppliers also frequently offered goods to the hospitals at specially discounted rates. Other useful donations included crutches, splints, surgical instruments, appliances, trusses and even an enema and attendant catheters.\textsuperscript{121}

Of equal significance was the wide range of smaller personal gifts and donations, the giving of which had a long-established pedigree. The small list of presents to the Leeds Infirmary in 1919 came from just over 100 individuals and thirty church communities and consisted of fruit, flowers, old linen and clothes, books and magazines, sweets, Christmas treats, toys and cigarettes. The donors were a mixture of trades, societies, churches and better-off individuals, such as Mr. Bland of Kippax who supplied twenty partridges, thirty pheasants and a forequarter of venison.\textsuperscript{122} Yet over the next ten years the profile of givers and the items given changed markedly as mass collection campaigns were instituted, especially for eggs and silver paper, bringing in a very wide range of volunteers, mobilizing significant numbers in outlying areas and prompting particular involvement from women and children.\textsuperscript{123} Lady Harewood’s Yorkshire wide ‘egg week’ had support from the Sheffield Hospital Council and the Rotary Club.\textsuperscript{124} In the mid nineteen-twenties it was collecting around 45,000 eggs for Sheffield, the figure rising – even in the Depression – to peak at 133,000 in 1934, a haul valued at £600 by Leeds General Infirmary.\textsuperscript{125} The figures in Nottingham were higher still. During the nineteen-twenties it regularly collected 90,000 eggs per year, and by the mid nineteen-thirties this figure had reached upwards of 150,000, plus the pickling brine to help preserve those not used immediately (Figure 4).\textsuperscript{126} The donations came in many sizes, sometimes a dozen and sometimes in their thousands.

Among the more traditional gifts were fruit, vegetables and flowers, mainly from elite figures and church harvest festivals. Large quantities of fruit were also received from traders at Leeds market. The elite contribution was increasingly supplemented by numerous community responses, from schoolchildren, clubs and societies, village hospital committees and some grocery companies.\textsuperscript{127} Leicester organized a ‘shield’ to encourage ‘competition between garden allotment holders to grow potatoes for the institution’.\textsuperscript{128} It similarly garnered gifts from harvest festivals, women’s and men’s institutes, allotment holders and gardening societies. Speaking for hospitals generally, the Sheffield Infirmary emphasized their ‘real value … resulting as they do in a saving of many pounds annually’.\textsuperscript{129} By the mid nineteen-twenties in Nottingham, the hospital’s potato week generated some forty-two tons of potatoes, six and a half tons of apples, one ton of turnips, and large amounts of fruit and other produce. In 1925, for example, a total of 339 consignments were received during the year from 194 sources. The considerable saving enabled the ‘Board, for the first time since the War, to give all patients and the staff butter instead of margarine’.\textsuperscript{130}

Of equal importance in terms of civic mobilization, although of considerably less value financially, was the collection of silver paper which also took off in the mid nineteen-twenties. Such activity was well suited to mass involvement – it was ubiquitous, could be collected by anybody, cost nothing and lent itself to communal efforts, by workpeople, pubs and clubs and, especially, the young. The Leeds list included thirty schools and scout and
guide troops, while many of the other donors were probably children like Master Allan Yates who donated 144 lbs of the material in 1929.\textsuperscript{131} The capture of support for the hospital cause among the community at large was most clearly exemplified by the role of unemployed workers, especially in Sheffield. Here the Council of Social Services arranged for furniture and splints to be supplied by ‘a number of men who, although unemployed, are desirous of helping the Hospital’.\textsuperscript{132}

Reflecting the enduring place of older, gendered traditions of middle-class giving, all of the institutions encouraged the development of Linen Guilds, which raised funds but also organized volunteers to produce substantial amounts of bedding and clothing for the hospital wards. As the subscriptions’ organizer in Nottingham recounted, it was the ‘most feminine of our many activities’, though adding generally that the ‘cash book was growing very steadily year by year’ in large part due to the fundraising activities of the women of Nottinghamshire, undertaken at a cost of ‘much personal effort and hard work’.\textsuperscript{133} As this implies, these were extensive operations. The Linen Guild set up at Leeds General in 1929 began with 1,200 members and an income of £500 and produced 1,949 garments in its first year. But by 1938 its membership had doubled and it was contributing 6,500 garments, supported by an income of £900.\textsuperscript{134} The Sheffield Royal Hospital even organized a Junior League, which had around 500 members by the mid nineteen-thirties and whose work focused on the nursery ward.\textsuperscript{135} At the Sheffield Royal Infirmary the board recognized that through the efforts of the Ladies’ Working Association, ‘many poor patients had reason to be grateful for the help given in connection with the loan of garments made by the members’.\textsuperscript{136}

The longest-running gift to patients and staff was the provision of Christmas presents and other festive treats. Mirroring the fundraising environment generally, these gifts became both more democratic and more organized. In Sheffield the collection of gifts was taken over by the Joint Hospitals Council and the distribution of presents became the task of the city’s Rotary Club – usually following a visit from the lord mayor and the master cutler. The Hospitals Council collected around £350 per annum in cash, plus gifts from traders, and more than 2,000 parcels were made up by the Rotary Club and the Ladies Auxiliary containing fruit, handkerchiefs, books, cigarettes, chocolates, sweets and toys, while all the nurses received a box of chocolates. In addition, large permanent toys such as rocking horses were sent to the children’s wards.\textsuperscript{137} Similar arrangements were seen at other hospitals, although on a more ad hoc basis.

The provision of gifts in kind was the most open and democratic of the contributions made to inter-war hospitals. In part because they relied more on time than money, activities like collecting tin foil or eggs or making garments for the Linen Guild could be undertaken by the young and old, and many of those involved were women and children. Similarly, the unemployed could give their time and their skills at no personal cost. For the middle classes, the new voluntary organizations formed during and after the war, such as Toc H, Rotary and Round Table, were all prominent in providing time, money and resources for the benefit of the hospitals, their patients and families. In Sheffield the Christian Toc H provided a library at both hospitals, as it did in Leicester. Similarly, the Rotary Club were involved in ‘conveying to and from the Hospital the relatives of patients who are taken seriously ill
during the Night’, in taking tonsil patients home after their operations, which relieved pressure on the ambulance service, and in bringing in blood donors at night. These were all tasks which required access to the new symbols of middle-class status – the motor car and telephone – while providing a space for social engagement for the younger or arriviste members of the elite who dominated these organizations.

The predominant orthodoxy among historians of both the urban elite and the inter-war hospital is that the middle class withdrew from involvement in voluntary and charitable activities in the face of competition from the working class, intervention from the local and central state, and historically high taxation. As a result, the voluntary hospital had to rely for its day-to-day income on patient payment, either directly through almoner-determined contributions or indirectly via mutualist contributory schemes. The most sophisticated research has also suggested that, though generally the value of capital assets was growing, by the nineteen-thirties this was less the case as debt rose too. Yet there has been little discussion of how the hospitals acquired the money for either fixed or current investments or the techniques utilized for raising ordinary income, or even money-saving gifts in kind. Through our exploration of the records of five leading provincial hospitals and the organizations which supported them, we have been able to test some of these orthodoxies and have provided a singularly more optimistic picture of the health of the voluntary impulse between the wars.

Across all of our cities voluntary or charitable giving to the hospitals remained significant, and in most cases actually deepened, in the inter-war period. Ordinary income from charitable sources, including free legacies, continued to grow in real terms and in three of the cities kept pace with, or outstripped, patient payment. Similarly, investments and fixed assets grew – quite significantly in some cases. Leicester especially amassed a huge war chest while seeing substantial physical expansion. Unlike ordinary income, which could draw on various sources of payment, adding to capital stock was entirely dependent upon charitable giving, either through gifts and benefactions, the products of public appeals or institutionalized annual events. Even gifts in kind seem to have increased markedly as mass collections were instituted, corporate interests replaced private, and new forms of assistance were required to supplement the more traditional activities of elite giving. Admittedly, this was not a linear process, nor was it felt equally in each place. As noted, charity seemed strongest in prosperous Leicester and Nottingham, weakest in Depression-struck Sheffield and most complex in Leeds.

Indeed, Leeds proved the most innovative within traditional boundaries, exploiting the widest range of sources, and, therefore, raising the most money in the later nineteen-thirties – though this was rarely enough to balance the ordinary account. Sheffield developed the most bureaucratic and instrumental regime, dependent on a quasi-insurance model which closely resembled the state system with its 25 per cent employer contribution. Yet Nottingham and Leicester managed to grow their income from their pre-war sources without resort to contributory schemes, challenging the conventional historiographical model. Voluntary engagement was essential to their success, though there was a certain reliance on the munificence of the Player brothers, Jesse Boot, Henry Mills and others from each city’s new rich. Their generosity continually outstripped that of the local landed elite whose...
function was to provide social rather than financial voluntarist leadership. These patterns, we believe, were closely shaped by a number of significant local factors. As has been noted elsewhere, the class structure and political culture of these cities influenced the shape and vitality of voluntary activity. The relative balance of charity and mutualism was also shaped by the structure and fortunes of industry, and the concomitant socio-political power of both employers and organized labour. Certainly, too, economic structures and experience were important. The place of new consumer industries, women workers and limited exposure to the staple sectors benefited Leicester and Nottingham, shielding them from the worst of the Depression and opening up new avenues for fundraising. Conversely, Sheffield’s fifteen years of poor trade in both the city and the surrounding districts weakened the already limited charitable sector and encouraged a dependence on the high-yielding contributory scheme. Once again the experience of Leeds sat somewhere in between, encouraging the development of a portfolio of income streams embracing voluntarism, mutualism and direct payment.

Yet economic downturn and unemployment did not, by themselves, significantly damage voluntarist income (despite hospitals’ fear that they would), although it is impossible to gauge how much greater giving would have been under conditions of economic prosperity and confidence. Indeed, it has been suggested elsewhere that in real terms levels of charitable giving continued to rise across the recession, only falling off in the later nineteen-thirties. The explanation for this growth lay in the embedded habit of giving and the organizational support that this required. It is clear that in all four urban centres, key groupings – be they community, associational or work-based – existed, and continued to exist, to enable this. Indeed, this activity expanded, as did the numbers of groups that supported it. It is clear, too, that in Nottingham and Leicester, overall, this was significantly more successful than in Leeds and Sheffield. In the former hospitals not only was this habit more deeply entrenched, but it continued to expand, whereas in Sheffield, as we have seen, for a large part of the inter-war period, charitable giving took second place to contributory mutuality. Thus, in part, at least, necessity drove a more voluntarist approach in Nottingham and Leicester, so that the hospitals themselves were more energetic in generating ideas, resources and local commitment because they had to be, as neither raised as much through payment and pre-payment schemes. Yet it was not simply a case of necessity; as important were attitude of mind and a community mentality, so that in one way or another, and through differentiating mechanisms, communities came together to provide a viable local hospital system. For the local hospital enthusiast, of whatever status, a commitment particularly in terms of time became a central facet of the yearly rounds of social fundraising activity, the fingers of which spread out into the broader community. Moreover, the strength of that attachment can be measured not only in terms of the money raised but by the plethora of community activities generated to support and identify with the hospital. One measure of this success is that – the shortcomings of the pre-N.H.S. hospital system notwithstanding – acceptance and approval clearly outweighed disapproval among patients and public alike. Nor was there any great popular demand for radical or overarching change, albeit that many favoured a more unified system of financing. It is noticeable, too, that the most rapid expansion of additions to fixed capital occurred in those two cities which most closely mirrored a twin-track approach to generating income, and that as identified earlier, the very
success of Sheffield’s ‘Penny in the Pound’ scheme had a significant negative impact on hospital charitable activity in the city in terms of raising money to meet everyday expenditure. In particular, the successful incorporation of the majority of the city’s employers into the scheme diverted funds from the main charitable sector: thus, money once classified as charitable was now re-labelled as ‘receipts for services rendered’. This was similar to the experience in Liverpool and Birmingham, where there was also extensive employer involvement in the contributory scheme, with the effect that voluntary income per bed was low (Liverpool) or fell sharply over the nineteen-thirties (Birmingham). 

These experiences suggest that contributory schemes were only a partial answer to the financial needs of inter-war hospitals. Quite clearly there was a wide range of differing experiences generally, but above and below the upper and lower decile markers in terms of voluntary activity across a run of voluntary hospitals – represented here in 1938 by Nottingham and Leicester, and the Royal Infirmary and Royal Hospital in Sheffield – the models were very different indeed. The poor economic situation in the region notwithstanding, the Sheffield scheme, with its extensive coverage, high level of contributions and significant employer input, limited the ability of the hospitals to call on either the middle class or the general public for additional donations. This is not to deny the success of the Penny in the Pound on its own terms – on the eve of the war, in 1938, the total income of the Joint Hospitals Council was £197,689. But it is significant, too, that the city’s voluntary sector adopted and adapted the principles and utilized the membership base of the Penny in the Pound to raise over half a million pounds for capital expenditure projects after 1938. Whether this represented the ‘Shape of Things to Come’ – as the Hospitals Council had branded the Million Pound Appeal – will remain conjecture. Similarly, whether the kind of mixed approach adopted in Leeds – and Nottingham from 1938 – or the charitably driven strategies of Leicester could have survived in the more ‘efficient’ post-war world cannot be answered. But what this survey has found is that charitable giving was still very much alive in 1938. It, more than patient payment, underpinned the capital expansion of the voluntary hospitals and their shift to modern institutions occupying a ‘warm place … in the life of the community’, able to ‘keep abreast with the progress of medical and surgical science, so as to be able to provide the best possible treatment for those who require its services’. 

Yet it is clear, too, that those hospitals that faired best were those that kept their options open. Thus, the earlier noted juggernaut which was the contributor system was also accident prone, at least in terms of the damage it did to other medical fundraising activity.

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Table 5

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Figure 1.
The enduring appeal of the traditional community response. Source: *Leeds Hospital Magazine*, May 1935.
Figure 2.
Appeals street hoarding, Leicester Royal Infirmary.
Source: Leicestershire County Archives, *Annual Report of the Leicester Royal Infirmary and Children’s Hospital, 1937* (Leicester, 1937) (reproduced with thanks).
Figure 3.  
Cover to the appeal brochure for the Sheffield Voluntary Hospitals’ Million Pound Appeal Fund, Sheffield, July 1938.  
Source: The National Archives of the U.K.: Public Record Office, MH 58/319.
Figure 4.
Large board advertising Nottingham General Hospital egg week.
Source: Nottingham University Manuscripts and Special Collections, Uhg X11 (reproduced with thanks).
### Table 1

Quinquennial current income by source and expenditure, 1919–38 (constant prices: base year 1928)

|        | Nottingham | General | Leicester Infirmary | Leeds Infirmary | Sheffield Infirmary | Sheffield Hospital |
|--------|------------|---------|---------------------|----------------|---------------------|-------------------|
| 1919–23 |            |         |                     |                |                     |                   |
| Philanthropic income | £111,800 | 44.2%   | £122,600 | 50.6% | £214,600 | 53.1% | £121,700 | 60.2% | £71,100 | 53.4% |
| Payments for treatment | £126,900 | 50.1%   | £117,200 | 48.4% | £150,100 | 37.2% | £68,200 | 33.7% | £49,400 | 37.2% |
| Total income | £253,200 |         | £242,100 |         | £403,800 |         | £290,900 |         | £132,900 |         |
| Total expenditure | £225,300 |         | £256,100 |         | £425,000 |         | £208,500 |         | £137,300 |         |
| Surplus/Deficit | £27,900 |         | -£14,000 |         | -£21,200 |         | -£6,300 |         | -£4,400 |         |
| 1924–8 |            |         |                     |                |                     |                   |
| Philanthropic income | £145,000 | 50.8%   | £192,200 | 52.5% | £286,700 | 58.3% | £137,300 | 40.0% | £106,700 | 38.7% |
| Payments for treatment | £137,800 | 48.3%   | £171,400 | 46.8% | £206,800 | 42.1% | £204,200 | 59.5% | £163,200 | 59.3% |
| Total income | £285,500 |         | £366,100 |         | £481,500 |         | £338,500 |         | £275,400 |         |
| Total expenditure | £280,900 |         | £384,200 |         | £530,800 |         | £293,500 |         | £241,800 |         |
| Surplus/Deficit | £4,600 |         | -£18,100 |         | -£39,100 |         | £49,700 |         | £33,600 |         |
| 1929–33 |            |         |                     |                |                     |                   |
| Philanthropic income | £201,300 | 55.2%   | £240,500 | 51.9% | £267,700 | 47.3% | £122,600 | 34.5% | £95,500 | 34.5% |
| Payments for treatment | £159,900 | 43.8%   | £219,500 | 47.4% | £296,900 | 52.5% | £234,300 | 66.0% | £171,700 | 64.2% |
| Total income | £364,800 |         | £463,400 |         | £565,700 |         | £360,900 |         | £267,500 |         |
| Total expenditure | £366,000 |         | £475,000 |         | £597,700 |         | £360,100 |         | £254,600 |         |
| Surplus/Deficit | -£1,200 |         | -£11,600 |         | -£32,000 |         | £10,700 |         | £33,600 |         |
| 1934–8 |            |         |                     |                |                     |                   |
| Philanthropic income | £238,500 | 56.7%   | £268,600 | 50.4% | £261,800 | 38.0% | £106,400 | 22.7% | £83,600 | 26.6% |
| Payments for treatment | £178,800 | 42.5%   | £257,600 | 48.3% | £413,400 | 60.1% | £354,200 | 75.4% | £230,000 | 73.2% |
| Total income | £420,600 |         | £525,800 |         | £688,200 |         | £554,600 |         | £514,000 |         |
| Total expenditure | £415,100 |         | £542,600 |         | £652,700 |         | £444,900 |         | £296,100 |         |
| Surplus/Deficit | £5,500 |         | -£9,800 |         | £35,500 |         | £29,700 |         | £17,900 |         |
| Total philanthropic income | £696,600 |         | £823,900 |         | £1,030,900 |         | £889,000 |         | £359,600 |         |
| Total current income | £1,324,100 |         | £1,604,400 |         | £2,149,400 |         | £1,370,200 |         | £989,800 |         |

Sources: Annual reports, 1918–39.
Table 2

Quinquennial additions to current and fixed assets, 1919–38 (constant prices: base year 1928)

|                  | Nottingham General | Leicester Infirmary | Leeds Infirmary | Sheffield Infirmary | Sheffield Hospital |
|------------------|--------------------|---------------------|-----------------|---------------------|-------------------|
| **Current assets** |                    |                     |                 |                     |                   |
| 1919–23          | £83,100            | £106,000            | £26,500         | £20,800             | £3,700            |
| 1924–8           | £6,300             | £67,500             | £3,000          | −£69,200            | −£53,800          |
| 1929–33          | £59,600            | £178,500            | £182,200        | £15,500             | −£31,300          |
| 1934–8           | £120,700           | £112,800            | £68,400         | −£32,000            | −£17,100          |
| **Total**        | £269,700           | £464,800            | £280,100        | −£64,900            | −£98,500          |
| **Fixed assets** |                    |                     |                 |                     |                   |
| 1919–23          | £104,000           | £92,100             | £12,500         | £12,200             | £5,400            |
| 1924–8           | £132,300           | £65,100             | £33,800         | £98,100             | £39,200           |
| 1929–33          | £73,900            | £99,800             | £4,400          | £40,400             | £13,700           |
| 1934–8           | £67,900            | £82,000             | £148,000        | £42,300             | £130,800          |
| **Total**        | £378,100           | £339,000            | £198,700        | £193,000            | £189,100          |
| **Combined total** | £647,800           | £803,800            | £478,800        | £128,100            | £90,600           |

Sources: Annual reports, 1918–39.