

# The Mixed Economy and the NHS across Morecambe Bay: Voluntary, Commercial, Charitable and Private Medicine, 1948-79

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## ABSTRACT

The third sector has been positioned as the key partner for successful integrated care at both system and national levels. Yet the NHS has always existed within a 'mixed economy' of healthcare; one with a 'moving frontier' between public, private and the third sectors. There has been continuity despite change and resilience within the local system against recurrent reform. This paper explores these continuities in Morecambe Bay from 1948 to 1979 covering voluntary, commercial, charitable, and private medicine across the historic tripartite division of the NHS. It demonstrates an enduring tension between bottom-up and top-down understanding of partnership between the NHS and other sectors mediated by place.

## INTRODUCTION

The voluntary, community, faith, and social enterprise sector (VCFSE) has been positioned by the NHS Confederation as 'the key partner' in making integrated care successful. '[L]ook[ing] and feel[ing] different from the past' are crucial.<sup>1</sup> Exploratory system findings in Lancashire and South Cumbria have found that resourcing, competition, and opposing organisational aims have limited integrated care gains locally.<sup>2</sup> At the national level the Hewitt Review highlighted that the NHS should better understand the role of VCSFE, independent and social care providers to make integration a reality.<sup>3</sup> In many respects, integration is a shared talking point within a dialogue of the deaf.

However, the NHS has *always* existed within a 'mixed economy' of healthcare from its creation in 1948. The 'mixed economy' is not rigid; instead, it is a 'moving frontier' subject to the ebbs and flows of political commitments between the public, private and third sectors.<sup>4</sup> Until 1979 maintaining a monopoly over the 'commanding heights' of the nationalised healthcare industry was part of a broad consensus. From 1979 to 1997 this was replaced by commitment to a market ethos and private sector growth. The third way promoted public-private partnership and a plurality of providers from 1997 to 2010 whilst commercialisation, community and charity alternatives remained ascendant until 2022 with the pivot towards integration. Each epoch remoulded, but did not reconstitute, the local system. There has been continuity despite these changes.

This paper explores these continuities and sectoral symbioses in Morecambe Bay during the early years of the NHS covering the stable 'classic' phase from 1948 to 1974 and its subsequent interregal crisis to 1979. It covers voluntary, commercial, charitable, and private medicine across its tripartite primary, secondary and community divisions. It demonstrates an enduring tension between bottom-up and top-down understanding of partnership between the NHS and other sectors which has constantly been mediated in place.

## VOLUNTARY CARE

Voluntarism within the 'mixed economy' of care during the 'classic' NHS was shaped by two relationships. Firstly, contractual arrangements between Manchester Regional Hospital Board (RHB) – on behalf of local Hospital Management Committees (HMCs) – and institutions disclaimed during nationalisation. Secondly, grant and case payments from local authority public health committees for voluntary personal social service providers. Each will be explored in turn.

### Contractual Arrangements with Disclaimed Hospitals

Whilst 3118 hospitals and clinics were nationalised in 1948, 277 remained outside.<sup>5</sup> Most were disclaimed following opposition from the Catholic Church.<sup>6</sup> Others soon followed, and a diverse group of institutions from nursing homes to acute hospitals provided just under 8000 beds between them, along with a handful of exclusive for-profit London hospitals.<sup>6</sup> However, most disclaimed hospitals entered into contractual arrangements with RHBs to provide beds for NHS patients given the virtual monopoly of the public sector. These contracts reflected pre-nationalisation patterns and many became *de facto* NHS institutions, with over half receiving more than 50% of their patients from the public sector by 1952. Dozens exclusively served NHS patients.<sup>7</sup> The majority were in London, exacerbating inequalities between the metropole and provinces. Of £4,113,862 spent by the 15 English RHBs on contractual arrangements in 1969, £2,110,499 came from the four London RHBs.<sup>8</sup> Disclaimed institutions accordingly represented a small but significant component of services at the system level.

Manchester RHB accounted for £349,411 of contractual spending in 1969, above the provincial average of £182,124.<sup>8</sup> The region contained 20 of the original disclaimed hospitals, most of which were small. The larger Royal Cheadle became responsible for rising expenditure into the 1960s as it became dependent on public funds for survival.<sup>9</sup> Elsewhere in the region, contractual arrangements provided beds in under-provided specialisms. Lisieux Hall in Chorley run by the Brothers of Charity contracted 203 of its 204 mental health beds to Manchester RHB. At the request of the RHB, St Joseph's Hospital adapted its 142-bed acute hospital in Preston to accommodate chronic and geriatric cases alongside its private patients.<sup>10</sup> The RHB shouldered some capital costs and paid more per patient than Ministry regulations permitted, but a lack of alternatives bred mutual reliance between the RHB and disclaimed institutions which were reluctantly tolerated by the centre.

Patients from across Morecambe Bay had limited, but crucial, access to contractual beds. Against the slow closure of small disclaimed institutions, the Brothers of St John of God acquired Hazlewood Hall in Silverdale in 1952 and converted it into a chronic sick hospital.<sup>11</sup> Lacking contractual arrangements, financial and personnel uncertainties inhibited services and by 1968 the hospital was transferred to the

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Missionary Sisters of Our Lady of the Apostles,<sup>12</sup> who rapidly secured agreement with Lancaster and Kendal HMC to provide 30 beds.<sup>13</sup> Further north near Carlisle, Silloth Convalescent Home provided beds primarily for the Cumberland and North Westmorland Advisory Committee of Newcastle RHB,<sup>14</sup> although many patients came from Morecambe Bay.<sup>15</sup> Silloth provided the *only* convalescent beds to East Cumberland HMC which eased seasonal bed blocking. The home remained in almost exclusive NHS use into the mid-1970s.

Contractual arrangements were not comprehensive service agreements. They were a series of bilateral relations between the RHB – on behalf of HMCs – and each disclaimed institution for beds. The Catholic Church was, like the NHS, deeply fragmented and there was no overarching structure. Yet the services they provided were highly regarded by local administrators who regularly defended them against routinely demanded cuts. Ultimately, in 1976 cash limits were imposed, and convalescent care became outdated with shorter lengths of stay and modern medical procedures.<sup>16</sup> Previously valued contractual arrangements became a sacrificial lamb to protect local services. Few remained by 1979.

### Local Authorities and Personal Social Services

Personal social services were the hallmark of local authority public health services under the NHS with the loss of their 'historic strongholds' of infectious diseases and municipal hospitals.<sup>17</sup> Whilst Medical Officers of Health (MOsH) guarded their residualised responsibilities, they supported

old and new voluntary organisations alike. In Morecambe Bay this meant supplementing patchy rural statutory services and complementing functions where central regulations curtailed jurisdictions.

Maternity and child welfare was a longstanding responsibility and family failure a perennial concern for voluntary organisations.<sup>18</sup> Shared interests served to shaped relations. Rural Westmorland relied upon partnership with voluntary, religious and community establishments to provide routine surveillance clinics.<sup>19</sup> In Lancashire, the Divisional Medical Officer (DMO) was the designated officer for supervising 'problem families'. Following government guidance, the DMOs for Furness and Lancaster Health Divisions (HDs) and Barrow's MOH chaired a local committee each where other statutory and voluntary services concerned were represented. These coordinating committees were the precursor of modern child protection systems: determining policy, maintaining registered families, and discussing cases.<sup>20</sup> The style of chairing was crucial, and routine inspections praised Lancashire's DMOs whilst condemning successive Barrow MOsH.<sup>21</sup>

Involvement with moral welfare developed during the Second World War, supporting mobilisation for total war, including new responsibilities to bring unmarried mothers into the workforce.<sup>22</sup> Mother and baby homes were disclaimed from the NHS with moral welfare considered a religious responsibility.<sup>6</sup> However, the state dictated, funded, and supported their activities. A 1943 circular determined that 'the most promising line of attack' was to 'co-operate with and reinforce the work of existing voluntary moral welfare

Year	Barrow	Westmorland	Lancashire HD1	Lancashire HD2
1948	3	4	0	1
1949	5	9	2	10
1950	5	11	4	20
1951	5	7	8	15
1952	6	10	5	16
1953	6	8	8	8
1954	9	4	8	6
1955	7	2	9	6
1956	6	8	6	4
1957	7	6	5	5
1958	6	5	6	8
1959	3	6	8	9
1960	8	3	5	12
1961	5	6	6	12
1962	8	9	4	18
1963	7	4	2	15
1964	8	1	8	13
1965	7	9	10	16
1966	12	4	4	12
1967	7	12	6	18
1968	14	15	11	23
1969	12	15	5	17
1970	2	*	2	15
1971	2	*	1	13

Table 1: Numbers of unmarried mothers sponsored by local authorities in Morecambe Bay for confinement in mother and baby homes and adoption of their child. Taken from annual reports of MOsH and CMOs, 1948-71. \* indicates lack of reporting.

associations<sup>1,23</sup> Grants for mother and baby homes and fees for individual unmarried mothers from local authority public health committees underpinned forced adoption between the 1949 and 1976 Adoption Acts.<sup>24</sup> Table 1 shows the numbers supported from authorities across Morecambe Bay, although fees were more often paid by mothers or families to uphold respectability, leaving the overall total far higher.

Support for family planning was new and came through the Family Planning Association (FPA). The Ministry was cautious. MCH and health committees led change using permissive powers.<sup>25</sup> From 1958 the Westmorland FPA branch ran contraceptive clinics in Kendal and by 1963 over 500 patients were being treated per year through additional sessions in Kirkby Stephen and Appleby.<sup>26</sup> John A. Guy provided financial support to the branch after their five-year FPA grant ended. He also advocated a new domiciliary service for 'problem families' along with P. G. Satow, the chair of the health committee. This involved targeting large or poor families for long-acting contraception to reduce the costs to the community.<sup>20, 26</sup> Eugenics lurked close to the surface.<sup>27</sup> Legislative changes in 1967 and 1974 legitimised, nationalised and expanded birth control services provided by the FPA across the NHS; the voluntary became statutory.<sup>25</sup>

## COMMERCIAL HEALTHCARE

Prior to the 1980 Health Services Act, commercialisation exerted little influence on the NHS. Even the 'cosy oligopolistic' British United Provident Association (BUPA) founded in 1947 aped old voluntary ideals.<sup>28</sup> The pharmaceutical industry had fewer qualms, and business boomed amidst the therapeutic revolution. Neither the 1959 Hinchcliffe nor the 1967 Sainsbury Reports succeeded in curbing spending through prescription limits or profit caps.<sup>29, 30, 31</sup> Curbs were only achieved with cash limits in 1976. Within the NHS itself, fee-for services and those subject to charges administered by Executive Councils (ECs) led commercialisation in pharmacies, opticians, and dentists.

There were three reasons for creeping commercialisation. Firstly, direct patient charges and fee-for services were a substitute to rising wages for both the Ministry and professional bodies. Secondly, charges and fees provided gatekeeping and rationing for the NHS, whilst growing private practice, particularly for dentists with limited recruitment.<sup>32</sup> Around one fifth of dental costs were met through patient charges for Barrow and Westmorland ECs in 1968-69; both were served by fourteen dentists for populations of 63,460 and 71,710 respectively.<sup>33, 34</sup> The same year dental charges increased by 50% to £1 and 10 shillings as a Labour Government compromise following the 1966 Sterling crisis.<sup>35</sup> Finally, they supplemented income. Ironically, many pharmacists profited through selling tobacco products,<sup>36</sup> although this also enabled rural dispensing to survive.<sup>37</sup>

## CHARITY AND THE 'CLASSIC' NHS

Prior to nationalisation the voluntary hospital system relied upon endowments from benefactors for buildings and equipment. By the interwar years most had deficits with rampant running costs falling beyond the scope of covenants. Only a small minority of prestigious teaching hospitals – mainly in London – held significant sums. Along with hospitals, endowments were nationalised in 1948. Difference mirrored their place in the NHS hierarchy. Teaching hospitals run by Boards of Governors

(BoGs) retained their sizeable portfolios. Endowment funds for RHBs were pooled into the National Hospitals Endowment Fund, the spoils being divided amongst all 377 HMCs. There was little guidance on where statutory funding ended and charitable purposes began, and their use leaned on local discretion over central direction.<sup>38</sup>

Endowment funds were complemented through local fundraising from leagues of hospital friends, perpetuating a 'traditional charitable relationship'.<sup>39</sup> There were also many health charities which supported services, amenities, and activities in conjunction with certain specialisms.<sup>40</sup> Whilst the sums were small in comparison to NHS spending, they insulated against political decisions over services. Blackpool and Wyre HMC offers an exemplary case study. In 1966 consultants protested the RHB's refusal to fund new cardiothoracic theatre supplies for the subregional unit, reluctantly using endowment funds despite considering this improper.<sup>41</sup> Similarly, the RHB refused support for a new consultant cardiologist proficient in cardiac catheterisation and concomitant theatre capacity owing to projected costs and increasing volumes of work in 1967. Having secured an anonymous donation of £27,500 and a matched sum through local fundraising, the RHB relented and supported the proposal, leading to Blackpool Cardiac Investigation Unit opening in 1969.<sup>42</sup>

Critics have argued that far from insulating against political decisions, charities 'distort health-service planning' as 'money goes to glamorous specialties and technologies, which involve running costs drawn from local budgets'.<sup>43</sup> Or, in the case of Blackpool, regional budgets as the unit served Pennine Lancashire and Morecambe Bay. This pointed criticism overlooks place in planning and providing services, where charity is a weapon of the weak to defend pockets of excellence outside teaching centres. Without this leverage, the RHB would further concentrate regional cardiac services at the distant unit in Baguley Hospital.

## PRIVATE MEDICINE

Private medicine and the NHS 'has long been a controversial issue'.<sup>44</sup> Contradictorily, the NHS was the largest private medical provider until 1976 when Barbara Castle, the Labour Secretary of State, committed to their eradication. Pay beds in the 'classic' NHS were a pragmatic compromise, part of Bevan's attempt to divide and conquer the medical profession by stuffing both consultants' mouths with gold.<sup>45</sup> Part-time contracts permitted senior consultants time for lucrative private practice but with most modern medical capacity nationalised, they negotiated using NHS beds in lieu of a residualised private sector.<sup>32</sup> These totalled 6,090 in 1948, declining to 4,350 by 1969, although occupancy rates hovered around 50%, and accurately costing and recovering patient payments proved onerous.<sup>44</sup> Private practice in NHS pay beds then, enjoyed a 'grudging consensus' until 1976 when intervention reduced them to 2,800 by 1979.<sup>46</sup>

There were clear geographical and hierarchical inequalities with private medicine. 2,573 of the original 6,090 pay beds were in London, and over 1,800 were in hospitals run by BoGs.<sup>44</sup> Increasing or reducing pay bed complements remained contentious throughout. Patients accessed private healthcare for familiar reasons: waiting lists, time with consultants, control over admission, and better facilities.<sup>47</sup> The insured population and coverage levels grew steadily,<sup>47</sup> whilst interwar hospital contributory schemes provided financial

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support with appliances and chargeable NHS services.<sup>48</sup> Accordingly, there was '[n]o sharp dividing line' between public and private within the 'mixed economy' of healthcare under the 'classic' NHS, even within hospitals or wards.<sup>47</sup>

The position of private medicine within Morecambe Bay must be understood in reference to Manchester RHB. Table 2 shows the numbers of allocated pay beds for the three Morecambe Bay HMCs and totals for Manchester RHB and BoG. Figures for North Lancashire and South Westmorland HMC include Lancaster Moor Hospital HMC – separate until 1964 – with the 1960 reduction resulting from declining occupancy and proposed modernisation.<sup>49</sup> A 1968 nationwide review reduced beds further depending upon occupancy levels.<sup>44</sup> In 1970, this was 42% for Barrow and Furness, 47% for North Lancashire and South Westmorland, and 100% for the Royal Albert against a regional average of 54%.<sup>50</sup> These averages fluctuated seasonally with beds reclassified for NHS demand. Despite low occupancy, North Lancashire and South Westmorland HMC had the highest number of pay beds for any HMC within Manchester RHB. This position continued beyond 1976.<sup>51</sup>

Reasons for the HMC's position can be found in evidence submitted by Manchester RHB to the 1972 Expenditure Committee. Firstly, the diffuse nature of hospitals as the HMC's scattered sites each had a handful of beds under the same consultants, artificially inflating the presence of private medicine. Secondly, a more affluent rural patient base removed from accessing either Manchester or London as the nearest preferable teaching centre. Thirdly, in the view of Manchester RHB:

Whilst it is difficult to adduce any firm evidence, there is a strong impression that the quality and number of applicants for consultant posts is adversely influenced in areas where the facilities for private practice are less than average.<sup>50</sup>

The HMC had longstanding workforce problems;<sup>52</sup> offering prospective consultants opportunities to supplement income was a recruitment strategy. A similar case position prevailed for West Cumberland Hospital which also struggled to recruit.<sup>53</sup> Conversely, and contradictorily, lucrative private practice was also a disincentive for new appointments in oversubscribed specialisms, often those with lengthy public *and* private waiting lists.<sup>54</sup> This predicament persisted after 1979.

Under the 'classic' NHS public and private health care 'intermingle[d].'<sup>47</sup> On the one hand private medicine relied on

NHS rationing for both patients and facilities, allowing the wealthy and senior consultants to benefit. On the other hand, private medicine allowed the NHS to secure demanded public services. It made hospitals more attractive for candidates, brought new specialist expertise, and provided a limited income stream for HMCs. This balance reflected the contradictory position of the NHS as the virtual monopoly public *and* private provider of medical care until 1976, when – ironically for a Labour Government – pay bed reductions were responsible for explosive private hospital and sector expansion.

### CONCLUSION

The 'mixed economy' of care inherited by the NHS persisted beyond 1948; the frontier between public and private simply shifted. This left administrators across Morecambe Bay scrambling to re-establish relations across the sectarian frontier through contractual relations with disclaimed hospitals. Local authorities used grants and case funding to provide services sanctioned by government policy but lacking legislative legitimacy. Commercial health was contained within services administered by executive councils. Charity, associated with hospitals and local identities, proved a minor but distorting influence on the availability of certain services. The NHS was the largest provider of public *and* private healthcare from 1948 until 1979. For Morecambe Bay this contradictory position saw private medicine influence the recruitment of consultants, the location and development of services, and the pace of specialisation.

Securing coordination and cooperation across the 'mixed economy' has never been easy. Throughout the 'classic' NHS the Ministry dispatched a torrent of circulars seeking to reduce duplication, advocate partnership, maximise resources, supplement and complement statutory deficiencies. The view from the centre – from above – was crude standardisation that ignored the tangled web of personal, professional, and political relationships between the NHS and other organisations. The view from the periphery – from below – was of aligning directives with the patchwork of scarce resources available, and making them applicable to the geographical, organisational, and spatial realities of Morecambe Bay regardless of their statutory or voluntary basis. The intermediate tier and regional politics of Manchester RHB provided a further filter.

Year	Barrow and Furness HMC	North Lancashire and South Westmorland HMC	Royal Albert HMC	Manchester RHB	Manchester BoG
1954	10	224	40	599	*
1956	10	234	40	605	*
1958	10	236	6	573	*
1960	10	62	3	404	*
1962	10	65	3	415	*
1964	10	65	3	414	*
1966	10	65	3	410	125
1968	5	37	2	319	89
1970	5	37	2	313	89

Table 2: Numbers of available pay beds in HMCs across Morecambe Bay, the Manchester RHB total, and Manchester BoG, 1954-70. See note 50 for source. \* indicates lack of reporting.

Today, this tension of integration from below and above remains. From above mandated integration seeks to formalise partnerships through governance arrangements that can be mapped, audited, and monitored. From below integration translates these aims into existing relations, constrained resources, and competing demands. The 'mixed economy' endures, providing a source of continuity as much as change. Whilst the policy architecture has shifted markedly from the 'classic' NHS to now, the key challenge of integration remains the same: articulating place and its needs beyond the perpetual demands for implementation from the centre. Place must have primacy.

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(a full list available on request)