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Journal of Social Policy / Volume 34 / Issue 03 / July 2005, pp 447 - 467

DOI: 10.1017/S004727940500886X, Published online: 15 June 2005

Link to this article: http://journals.cambridge.org/abstract_S004727940500886X

How to cite this article:

MARTIN GORSKY, JOHN MOHAN and TIM WILLIS (2005). From Hospital Contributory Schemes to Health Cash Plans: The Mutual Ideal in British Health Care after 1948. *Journal of Social Policy*, 34, pp 447-467 doi:10.1017/S004727940500886X

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From Hospital Contributory Schemes to Health Cash Plans: The Mutual Ideal in British Health Care after 1948

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Abstract

The article traces the post-war history of the British hospital contributory schemes, which had developed during the inter-war years to the point where, through the accumulation of small weekly contributions from a mass membership, they provided substantial proportions of hospital income. A minority of contributory schemes remained in existence post-1948, but their subsequent development has received little attention. Some evolved into provident associations offering private health insurance; others remained committed to the provision of low-cost benefits to a blue-collar clientele, and continued to be known as hospital contributory schemes. This article outlines the principal features of the contributory schemes' contemporary history. We first explore why many schemes decided to continue in existence. The next section uses national and individual scheme records to delineate the market niche which they captured and to investigate their role in post-war health provision, relative to the state system. In particular we trace the decline of convalescent home benefit, and the gradual trend towards a more uniform benefit package, of which optical and dental grants were the most popular. We then survey patterns of membership and account for the main trends in support for cash plan products since 1950. Finally, we ask to what extent the schemes were able to retain their character as a 'movement' with distinctive mutualist and charitable features, particularly in the more competitive environment of the later twentieth century.

Introduction

Private medical insurance (PMI) in contemporary Britain is commonly understood as the purlieu of the non-profit provident companies, dating back to the 1940s, and the for-profit, commercial insurers which entered the market from the 1970s (Higgins, 1988: 90–100, 124–139). Less well known are the health cash plans, which, although they share some characteristics with provident insurers, differ with respect to membership and benefits. The most obvious similarity is their common antecedence in the hospital contributory scheme movement,

which flourished prior to the National Health Service (NHS) (Abel-Smith, 1964: 311–18, 323–337). The purpose of these schemes was to channel subscriptions to the voluntary hospitals. Some schemes operated on a quasi-insurance basis, catering to working-class contributors; membership carried no contractual right to treatment, but it did excuse patients from means-tested charges imposed by hospitals. Others offered insurance-based pre-payment ‘provident’ arrangements to those on higher incomes, a development which coincided with the growth in private pay-beds. At their peak the schemes had enrolled some 10 million contributors and, when allowance is made for dependants, perhaps some 20 million people were eligible for benefits (Beveridge, 1942: 160). Most schemes were associated with a single hospital, but a number were organised on a city-wide basis, raising funds which were pooled and distributed among hospitals. The largest, the Hospital Saving Association (HSA) based in London, had over two million contributors.¹ Following the establishment of the NHS a minority of contributory schemes remained in existence. Some chose to cater to middle-income groups who wished to insure for private consultations and in-patient accommodation: 17 such schemes amalgamated in 1947 as the British United Provident Association (BUPA) (Higgins, 1988: 30). Others remained committed to the provision of low-cost benefits to a blue-collar clientele, and continued to be known as hospital contributory schemes. The development since 1948 of these latter associations, now dubbed ‘health cash plans’ (HCPs), is the subject of this article.

Thus far, scholarly interest in the schemes has been limited to their role before the NHS, demonstrating the part they played in rescuing voluntary hospital finances and their role in altering the hierarchical structure of management by securing places for scheme representatives on hospital boards (Cherry, 1992, 1996, 1997; Gorsky *et al.*, 2002). However, most accounts of the coming of the NHS accord them barely a mention, while analyses of PMI typically make only glancing references to them (Webster, 2002: 31, 36, 46–47; Honigsbaum, 1989: 159–160, Calnan *et al.*, 1993: 28; Maynard, 1982: 140–141). Although this disregard reflects the small scale of the schemes’ economic activity in comparison to PMI (HCP income c. £400 million, PMI £2.9 billion, Laing and Buisson, 2003), it is in some respects surprising. First, their scale is quite significant: during the 1950s the continuing schemes claimed some three million subscribers, a figure which was only reached by the provident insurers in 1989 (Office of Health Economics, 1995: table 2.2), and, numerically, cash plan membership is comparable to PMI coverage. Second, although post-war governments have remained committed to an NHS principally financed by general taxation, discussion of the potential benefits of an insurance model has periodically recurred (Seldon, 1968). Currently, there are continuing signs of New Labour’s willingness to explore co-payments in the public sector (Blair, 2003; Mayo and Moore, 2002), as well as debate about the potential of locally organised, non-profit ‘Supplementary Mutual Funds’, on the model of the cash plans (Keen *et al.*, 2001: 217–220). Third, policy analysts look increasingly to

new forms of economic and social governance in which the third sector is used to deliver welfare services (Hirst, 1994, 1999; see the response by Stears, 1999). This involves exploration of the potential of voluntary and mutual associations (Deakin, 2001; Kendall, 2003). Important recent developments in the NHS draw explicitly on a historical rhetoric: thus the new NHS foundation trusts are said to be ‘modelled on co-operative and mutualist traditions’ (Department of Health, 2003a), though the empirical justification of this ‘new mutualism’ in hospital governance rests not on studies of the earlier hospital contributory schemes themselves but on other businesses and associations (Department of Health, 2003b: 7–10; see, however, Mutuo, 2002).

Against this background of a search for organisational reform which may offer new opportunities for the surviving cash plans, we outline some fundamental features of the contributory schemes’ post-1948 history and contemporary development. The first section asks why many schemes decided to continue in existence. The next section uses national and individual scheme records to delineate the market niche which they captured, and to assess whether their role has been essentially complementary or supplementary to the NHS (Mossialos and Thomson, 2002: 24–25). We then survey patterns of membership and account for the main trends in support for cash plan products since 1950. Finally, we ask to what extent the schemes were able to retain their character as a ‘movement’ with distinctive mutualist and charitable features. The main sources are the records of the representative body, the British Hospitals Contributory Schemes Association (1948) (BHCSA), known since 1988 as the British Health Care Association (BHCA), and the archives of schemes of varying sizes, in Sheffield, Leeds, Liverpool, Birmingham, Bolton, Bristol and Wolverhampton.

Continuation under the NHS

By financing hospitals from direct taxation, the nationalisation of the hospitals might appear to have removed the *raison d'être* of the contributory schemes. Although some 200 folded after 1948, 35 continued to operate, mostly those which had been independent of the local voluntary hospital, with a Board of Trustees or registered under the Companies Act (Page, 1949: 30).² Some of these schemes still operate today as health cash plans, albeit fewer than in the 1970s when there were 32 affiliated to the BHCSA, as against 17 today (Palliser *et al.*, 1984; BHCA, 2003). Indeed, when the national picture of continuing membership became clear in 1950, the schemes could claim some 3.4 million contributors, a figure which may be compared to the 56,000 who subscribed to the early provident health insurance plans (Higgins, 1988: 47).³ Given that the majority of pre-1948 members had been workers in the lower-income brackets, this level of support under the NHS may seem surprising. How is the continuation of the movement to be explained?

Despite the working-class character of the contributory schemes, neither the Labour government nor the labour movement gave much encouragement

to their continuation. The Minister of Health, Aneurin Bevan, enjoined the BHCSA to '(w)atch to see where the shoe pinches first... and if the nation cannot do it, there your voluntary services will be required'.⁴ This apparently supportive statement was not backed up with action. Hospitals were instructed to cease their charitable fund-raising activities and to wind up 'contributory schemes run by the hospitals themselves';⁵ fears of conflicts of interest led to the disbarment of committee members of continuing schemes from serving on Regional Hospital Boards and Hospital Management Committees;⁶ and although the administrators of single-hospital schemes were absorbed into the new service, no place was found for officials of independent schemes, who faced unemployment without compensation. Furthermore, some trades councils opposed plans for continuation; reasons included suspicions that the schemes undermined Labour's goal of universalism, objections to continued deductions from pay packets, and a belief that the main motivation was the protection of the jobs of existing scheme officials.⁷

Against these countervailing pressures, four key factors underpinned the desire to continue. First was the practical reality: here were associations with considerable assets, including the skills of their volunteers and paid employees, their accumulated capital, and their property, principally in the form of convalescent homes. Second, at the ideological level there was a commitment to 'perpetuating the great tradition of voluntary service' under the welfare state.⁸ 'It is democracy at work', argued the Merseyside Hospital Council, appealing to 'the sense of real sportsmanship, to the desire for self help and to the sound moral outlook of the average British citizen'.⁹ Third, many schemes were ingrained features of civic life and workplace culture, with most members subscribing through their firm's payroll (Cherry, 2000). Fourth, although there are no survey data from the early NHS period to confirm this, it seems certain that members must have perceived as valuable the benefits which the schemes offered. Thus in Merseyside for example, despite vocal opposition from the local trades council, some 267,500 remained in the continuing scheme by 1950 (compared to 388,000 in 1946) and this number had grown to 355,000 by 1957.¹⁰ Above all, then, the schemes tapped a consumer demand.

Where did the shoe pinch? The development of a market niche

The implication of Bevan's quote was that the parameters of the post-1948 development of the schemes would be set by the activities of the NHS. What trends can be discerned in the take-up of the benefits provided by the schemes? No comprehensive time series of benefits is available from the central BHCSA archive, so instead it is necessary to examine the records of individual schemes.¹¹ A full sequence detailing benefit claims survives for the Leeds Hospital Fund (Figure 1), which, with 160,000–220,000 members for much of this period, is reasonably

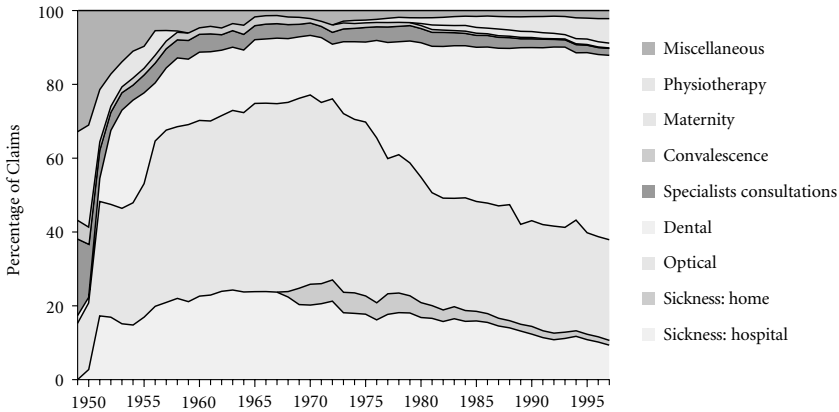


Figure 1. Main categories of claims made by members of Leeds Hospital Fund, 1949–1997.

typical.¹² Initially, claims were mainly for accommodation in the scheme's convalescent homes, along with limited grants towards specialists' consultations, and two benefits which were soon dropped: grants for chiropody and surgical appliances. Here such items are grouped in the 'miscellaneous' category, which also included provision of home helps and surgical appliances. However, by the early 1950s three key benefits had emerged: a cash payment while members were hospitalised, and grants towards the costs of spectacles and dental care. Then, from the 1960s a cash payment for members sick at home was introduced. The most striking long-run trends were the consistent importance of the hospital benefit, the marginal significance of convalescence and the growing attraction of the dental and optical grants, which from the early 1950s accounted for some 50 per cent of all claims. Note that because of the small size of optical/dental claims, a graph of expenditure would show that hospital cash benefits accounted for a much higher proportion (sometimes over 50 per cent) of benefits paid.

Other scheme records present regional variants of this picture, depending on the timing of the introduction of new benefits. For example, the Merseyside scheme did not introduce optical and dental benefits until several years after the institution of NHS charges, while the Birmingham and Sheffield schemes offered only convalescent home accommodation in the early phase of continuation. By the late 1960s, however, the hospital grant was the most popular benefit in cash terms, with the growth of optical and dental expenditure taking off from the late 1970s. Other schemes also conformed to this general pattern, and regional variation gave way to greater uniformity by the 1980s.¹³

The contributory scheme/cash plan market has therefore been essentially complementary to the NHS from the outset, in that it provides a range of

benefits which fall outside the state scheme. Only the grants towards specialist consultations can be deemed supplementary, and similar to PMI, in that they allowed claimants to purchase a service they might otherwise have received free from the NHS. This benefit, however, has not been a very large component of expenditure, since it typically offered only a proportion of the consultation fee, and was hedged around with restrictions. In Leeds, for example, such grants paid up to two guineas per consultation but could be claimed only once in a year, while in Wolverhampton, they paid only 50 per cent of the fee, up to £3 per annum.¹⁴ They were also frowned upon by the BHCSA leadership, which believed they were 'aiding and abetting queue jumping'.¹⁵

Beyond this, the schemes colonised areas which were excluded from the ambit of the NHS. Convalescent homes had multiplied during the early twentieth century. They were either affiliated to voluntary hospitals, which used them to prevent bed-blocking, or operated by associations such as trade unions, friendly societies and contributory schemes, which offered accommodation as a welfare benefit. In 1948 government decided to 'disclaim' some 230 hospitals which were deemed surplus to the requirements of the NHS, including many convalescent homes (Higgins, 1988: 32). Continuing schemes were therefore able to offer this additional benefit, either in their own institutions or through meeting the fees charged by independent homes. Popular locations for convalescent institutions were in rural areas or coastal resorts thought to be conducive to recuperation. A medical recommendation was necessary to claim the benefit, which might also include travel expenses and pocket money.

By contrast, the hospital cash grants were a new product, developed on the premise that, despite the universal national insurance ushered in by the welfare state, an episode of sickness was still likely to entail a loss of earnings. They also echoed earlier traditions of friendly societies' sickness pay, and their founder was a friendly society activist (Wren, 1985: 5, 13). BHCSA discussion documents in the late 1940s had promoted the cash grant idea, and, by 1952, 22 out of 27 affiliated schemes operated it.¹⁶

The dental and optical grants responded more clearly to consumer demand in an area where, from the outset, government had allowed some scope for patient charges. These were initially intended to be for repairs and replacements, though in 1951 charges of about half the cost of dentures and for spectacles the full price of frames and 10s per lens were ushered in (Webster, 1988: 179–180). Having promoted a repairs benefit since 1948, the BHCSA was well placed to advise their affiliates on grants towards these new costs.¹⁷ In 1951 one of the most prominent figures in the pre-war contributory schemes movement, Sir Alan Anderson of the Hospital Saving Association, foresaw the opportunities which the imposition of charges would bring: 'new needs would arise which were not contemplated when the health service was formed'.¹⁸ Figure 1 suggests a clear association between changes in NHS charges and patterns of take-up in Leeds, and this was repeated

elsewhere, with claims for optical benefits rising dramatically in the 1950s, and those for dental treatment climbing from the 1970s onwards.¹⁹ From the late 1970s optical and dental benefits grew to around 35–40 per cent of the total benefits paid in Sheffield and Merseyside, and in Leeds, by the late 1980s, as NHS dentistry declined, dental claims accounted for some 40 per cent of all claims. A recent survey into the attitudes of present-day contributors to the Bolton and District Hospital Saturday fund revealed that optical and dental grants are still those deemed most important by members (Green, 2001: 146).

The growing popularity of optical and dental benefits helps explain why the incidence of claims steadily increased throughout the post-war period. In the Leeds Fund, there were typically between 20–30 claims per 100 members in the 1950s, but by the late 1980s the incidence was nearer 90 claims per 100 members, and recent data indicate that the total number of claims made exceeds the number of subscribers. This reflects the increasingly small size of the claims and did not signal a threat to actuarial viability. In Wolverhampton, for example, optical and dental claims constituted 52 per cent and 25 per cent of all claims in 1960, while accounting for 14 per cent and 18 per cent respectively of expenditure.²⁰

Another long-run trend discernible in all the schemes surveyed was the decline of convalescent home benefits. This is best understood in the light of changing norms of non-acute care, as doctors became less inclined to recommend institutional convalescence to patients who did not require active nursing or treatment.²¹ A Ministry of Health enquiry in 1959 questioned the therapeutic value of what officials described as ‘recuperative holidays’.²² The BHCSA preferred the epithet ‘traditional convalescence’, although it was frankly acknowledged that this meant: ‘a recuperative stay in pleasant surroundings... the sort of rest that the more well to do are able to provide for themselves in a suitable hotel’.²³

There is evidence that the ‘seaside holiday’ element of convalescence, rather than its medicinal aspects, was central to its appeal. Thus the Leeds fund reported that take-up of its inland homes on the Yorkshire Moors had fallen off in favour of the coastal institutions, particularly in the winter months.²⁴ Consumer preferences were also shifting away from the old-fashioned, institutional atmosphere of the homes.²⁵ In 1966 the Merseyside scheme summarised matters thus: ‘Changes in social conditions, the advent of the Welfare State, increases in wage rates, and improved standards of medical diagnosis and treatment have... created different outlooks on convalescence’.²⁶ BHCSA appeals to the Ministry of Health to open up spare capacity to local authority contracting for aftercare (and thus to public monies) met with a negative response.²⁷ Thus without statutory support for a re-orientation of these recuperative facilities, decline in their utilisation continued apace; convalescence benefit fell as a percentage of the total distribution of schemes affiliated to the BHCSA from 15 per cent in 1969, to 10 per cent in 1973, to 5 per cent in 1982.²⁸ With it went a vital

part of the identity of the movement, which to BHCSA leaders had represented a 'shop window of our schemes'.²⁹

Recent data demonstrate a continuation of these trends. Of some 6.1 million claims made in 2002, 3.6 million were for dental and optical benefits, averaging £24 and £55 per claim respectively. In cash terms the largest category of benefits was payments associated with in-patient stays (26 per cent), with dental (21 per cent) and optical (24 per cent) claims close behind. The number of claims for dental and optical benefits had increased by 75 per cent compared with 1999. Other than that the most dramatic increases were in physiotherapy and chiropody, together representing some 12.5 per cent of benefits paid (Laing and Buisson, 2000, 2003). These trends indicate, in part, the extent to which dental and optical services are now a private responsibility, and in part the difficulties of obtaining services such as physiotherapy on the NHS; certainly the evidence available on the marketing strategies of the cash plans suggests that they are being marketed (especially to companies) as occupational health packages which will reduce absence rates and enhance productivity.³⁰

Membership

Figure 2 shows the membership numbers of contributory schemes/health cash plans in the era of the NHS, set against the trend in numbers of PMI subscribers. Estimation of membership data is subject to a margin of error. Since the majority of contributions continued to come through workplace payroll deductions rather than individual payments, schemes typically kept no record of the exact numbers of subscribers. Instead they estimated their membership based on potentially obsolete records of the size of constituent firms and few thought

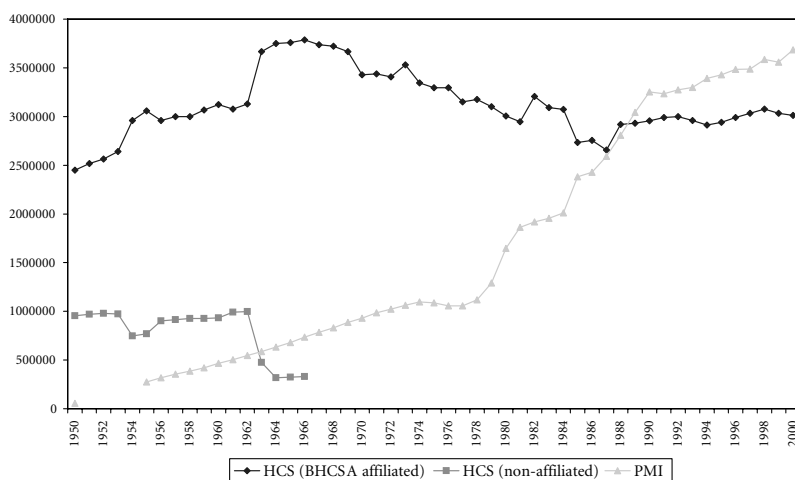


Figure 2. Numbers of subscribers to hospital contributory schemes (HCS) and to private medical insurance (PMI), UK, 1950–2000.

it worth publishing totals in their annual reports. The main source for these figures is therefore the collated statistics of the BHCSA/BHCA, which itself is an aggregation of these imprecise estimates.³¹ Even these do not give the full picture, as some schemes were not affiliated to the BHCSA, and their membership went unrecorded after 1966; others suspended their affiliation for parts of the sequence under review. As the graph shows, however, the numbers not affiliated declined quite markedly, particularly after the early 1960s when the Birmingham Hospital Saturday Fund joined the BHCSA. From then on it seems that fewer than one in ten members was in an unaffiliated fund, and it is reasonable to presume that these national figures fairly reflect actual trends.³²

Two further difficulties with these figures should be noted. First, there is no national record of the balance between individual subscribers and those whose membership was by dint of joining a participating firm. Individual scheme records from the North and Midlands show that firm membership predominated at first: only about one in ten members was an individual subscriber in the late 1950s.³³ BHCSA examination in 1970 broadly confirmed this pattern but noted that individual membership was unusually high in areas such as Bristol, Exeter, Hull and Reading.³⁴ In the 1980s the balance began to change, with the Merseyside fund, for example, drawing about one-third of its income from individuals by 1990. The second aspect which these figures obscure is the varied geography of contribution. The essentially urban basis of the movement persisted, with rural areas considered to be 'difficult and expensive in which to campaign'.³⁵ Nor did the funds have a genuinely national constituency, with large areas remaining 'uncovered', including Scotland, Northern Ireland, the North-East of England and the far North-West.

With all these caveats in mind, what were the main trends? If non-affiliated schemes are included, scheme membership rose from a base of about 3.5 million at the start of the NHS to reach about 4 million in the 1960s. It then entered a slow decline through the 1970s and 1980s, before stabilising and recovering slightly in the 1990s. This pattern contrasts vividly with the trend in subscription to PMI which after slow growth in the post-war period entered a period of rapid expansion in the last two decades of the century. The forces driving the growth of private insurance are well known, and include aggressive advertising strategies which capitalised on disenchantment with the NHS, the advent of American commercial insurers, and the rising real incomes of social groups most likely to purchase PMI (Higgins, 1988: chapter 3; Calnan *et al.*, 1993: 2–18; Propper and Eastwood, 1989: 12–15). Many businesses were prompted to offer employee and company purchase schemes as perks, either to circumvent incomes policies or to attract scarce staff in competitive labour markets. Thus there was a strong social gradient in the distribution of PMI with some 28 per cent of professional and managerial socio-economic groups reporting that they were covered. There were also strong regional contrasts (ONS, various dates).

Quite different factors determined trends in contributory scheme membership, for PMI products were not direct substitutes for cash plans. Three issues underpinned the rise in scheme take-up in the 1950s: first, the re-establishment of cordial relations with local trades councils, which overcame opposition to payroll deductions and encouraged the voluntary work of collectors, both inside and outside the workplace; second, the success of the schemes in tailoring benefits packages and subscription levels (on average 3½d per week in 1956) to their market; and, third, the imposition of optical and dental charges, which boosted demand.³⁶ The beginnings of decline in the late 1960s were initially explained in terms of profile and publicity: ‘are we hiding our light under a bushel?’ wondered the BHCSA President in 1967.³⁷ By the mid-1970s, though, real problems were developing. It became harder to replace the ageing, long-serving volunteer collectors;³⁸ at the same time, strikes, inflation and unemployment meant that for the BHCSA ‘signals are firmly set at danger’, with ‘factory closures, and redundancies’ undermining membership in the movement’s heartlands.³⁹ Matters became ‘gloomier still’ at the end of the 1970s, and BHCSA leaders ruefully contrasted the acceleration of PMI membership with their own performance: ‘what we have to sell is less attractive and our marketing methods are less efficient’.⁴⁰ There was a push to raise the schemes’ profile in the late 1980s and early 1990s, with the engagement of two parliamentary representatives, the employment of a public relations firm, and the renaming of the national body as the British Health Care Association, with a full-time Secretary.⁴¹ The rebranding of the schemes as ‘health cash plans’ and a concerted effort to update their image also aided recovery, as did the restructuring of benefits to include grants for complementary medical care, though as yet these account for only a small proportion of benefits paid. Finally, there is some suggestion that the rising tide of PMI in the 1990s may also have lifted the cash plans. The Family Resources Survey for 2000–01 estimated that 18 per cent of the population had some form of health insurance, whether health cash plans or PMI, and that since an estimated 10 per cent of the population had health cash plans and 12.3 per cent had PMI, it was probable that some 5 per cent subscribed to both products (Family Resources Survey 2000–01, cited in Orros, 2002: 5). The suggestion, then, is that the greater visibility of cash plan products promoted by provident and commercial insurers may now be boosting scheme membership too. Even so, only some 15 per cent of cash plan policies are company-paid; this contrasts sharply with PMI, where only approximately one-third of policies are individually paid (Laing and Buisson, 2003), suggesting that the cash plans are a much less important aspect of corporate welfare than PMI.

Consideration of the whole post-war period points to two further aspects of the schemes’ constituency which have influenced membership trends. First, they have retained strong local and urban identities. Local loyalties were vital to their post-war recovery, and recent research into the relationship between

a scheme's town of origin and its brand recognition has suggested that these remain an important motivator of cash plan purchase (Green, 2001: 194). At the same time, localism militated against expansion into parts of Britain where coverage was low. Efforts to establish regional groups to promote the movement over the whole country got underway in the 1960s and initially made some headway in the Midlands, the South West, Yorkshire and the North-West (the latter group continuing to meet into the 1990s).⁴² However, none of these groups was located in the regions identified as areas on which recruitment efforts might be targeted (see above). Also, some schemes underwent renaming exercises designed to loosen their identification with a particular place and to broaden their geographical appeal: thus the Sheffield fund became the Westfield Contributory Health Scheme in 1974, while the Wolverhampton scheme became simply the Patients Aid Association.⁴³ However, just as in the 1930s, an element of parochialism and a jealous regard of local control militated against such initiatives. As a representative of the Bolton fund put it in 1965: 'My committee will not join in any regionalisation whatsoever . . . We are a local body'.⁴⁴

Second, although we have no firm data on their social composition, it seems fairly clear that the cash plans have continued to restrict their appeal to a lower-income group than that reached by PMI. Labour movement ties remained important throughout the period. For example, when the Leeds fund attempted in 1965 to recruit members at a shipbuilding firm in Sunderland, it found that the employees were more receptive to approaches made 'through the trade union side' than through management.⁴⁵ Trade union support has remained important: for example, Medicash (the Merseyside scheme) currently operates a 'Unison Endorsed' health cash plan.⁴⁶ Has this been a help or a hindrance? It seems likely that just as the movement's localism constrained geographical expansion, so its rootedness in the culture of workplace association circumscribed its social appeal. The dilemma was nicely captured in this letter from a Cornish member to the Secretary of the BHCSA; he noted that membership of the main private health insurance schemes:

can be boasted of in the clubhouse after 18 holes. [However] Flashing your contributory scheme membership card would probably get you drummed out of the club. Sadly our image just hasn't been updated: we are still a cloth cap and muffler set up. We are working class and there is nothing wrong with that, but unlike years ago there is no longer any pride in being working class.⁴⁷

In this reading, then, a low national profile, a localist and socially restricted constituency, reliance on a substantial input of voluntary effort, and an outmoded image emerge as the most plausible explanations for the difficulties experienced by cash plans in reinvigorating their membership in the late-twentieth-century.

Recent trends have therefore seen a different approach. Marketing of the plans to companies now emphasises the complementarity between the plans and

PMI, with firms offering PMI to senior staff and making cash plans available to a broader spectrum of their workforce. The marginal cost of adding HCP coverage to a private medical insurance policy is not large. And the largest scheme, the HSA, has dropped the title ‘cash plans’ in favour of the term ‘everyday health plans’;⁴⁸ one inference is that certain health-related expenditures are seen as an everyday occurrence or risk as they are no longer borne by the state. These marketing strategies – occupational welfare and coverage of out-of-pocket expenses – are essentially consumerist and self-interested, and they raise the question of whether the ‘movement’ can continue to adhere to its original character.

The mutual aid ethos in the post-war period

It is perhaps no surprise that the contributory schemes/cash plans lacked a conventional commercial instinct, given their idiosyncratic structure and ethos. The continuing organisations retained many features of their predecessors. They were non-profit organisations and, unlike private insurers, they did not challenge the principle of a collective risk pool embodied in the NHS, nor did they seek to offer a superior alternative. At the outset they also considered themselves as much charities as insurance providers, and regarded themselves as a ‘movement’, acting in concert rather than competition with each other. Here we assess the extent to which the schemes were able to retain aspects of their mutualist origins.

For government and for financial regulatory bodies, there is confusion about the status and identity of the schemes: are they primarily insurance companies or are they community-based voluntary organisations with strong charitable features? The charitable *origins* of cash plans are indisputable as they lie in the collection of funds for voluntary hospitals, and although pre-NHS contributors almost certainly viewed scheme membership as a form of insurance, the schemes persisted in presenting themselves as charities, not least because if contributions were treated as ‘gifts’ to the hospital they were not liable for taxation (Gorsky *et al.*, forthcoming). On the establishment of the NHS, the BHCSA leadership was quick to argue for retention of charitable status, and in fact this legitimately reflected the activity of the majority of schemes, which established new procedures for giving to local hospitals, either from assets or by setting aside a proportion of contributions for philanthropic purposes. The BHCSA’s claim was accepted by the Treasury, allowing schemes to receive repayment of income tax on proceeds of their investment income. However, under the Charities Act of 1960, the schemes’ status as charities was removed, prompting several to establish separate Charitable Trusts through which their giving was channelled and which were still liable for tax relief (Palliser *et al.*, 1984: 20–23). Some were also permitted to finance their convalescent homes through charitable trusts, thus retaining some tax benefits for members. In 1967 they were classified for the first time in law as insurance companies under the Insurance Companies Act.⁴⁹ The warning issued that same year by the BHCSA secretary, John Dodd, that the schemes were ‘in danger of

becoming cash mutual insurance societies, rather than voluntary social service organisations' embodies the movement's own uncertainty about its identity, at a time when lawmakers sought clarity.⁵⁰

What did the schemes' charitable work mean in practice? The NHS Act had restricted charitable effort in the NHS to the provision of amenities and comforts for hospital staff and patients and to the furtherance of medical education (Mohan and Gorsky, 2001: 91–95). Examples of amenities provided by Sheffield Hospital Council in the early phase included radios, pianos and 24 televisions in time for the Coronation in 1952.⁵¹ It also attracted the support of volunteers for its hospital cinema service, and for the wrapping of Christmas presents donated by the scheme (14,000 such gifts were made in 1966).⁵² In time, though, the amenities aspect of charity work gave way to systematic donation of grants to health and social service organisations and the provision of equipment to hospitals (Palliser *et al.*, 1984: 10).

The extent to which the volume of this charitable activity has altered over time is hard to gauge at a national level. One estimate was that from 1948 to 1983 the movement gave £7.4 million pounds in charitable gifts (Palliser *et al.*, 1984, 10). However, there have been variations in the relative amounts committed by the different schemes and not all of them have operated charitable arms: in 1968 only 18 of the 30 funds affiliated to the BHCSA made charitable gifts out of contributory or investment income.⁵³ One way to reconstruct trends in charitable effort is to measure the amounts given annually against overall income from contributions. Figure 3 does this for four (anonymised) schemes. Charitable spending was a rather more substantial aspect of the schemes' work in the early part of this period, but since the 1970s the amounts committed have settled at about 3 per cent or less of income, albeit with some variation around this general

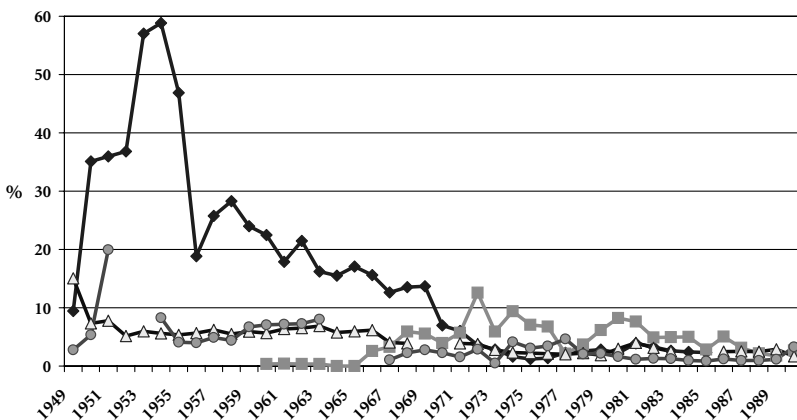


Figure 3. Charitable expenditure as % of contributions, selected hospital contributory schemes, 1949–1991.

pattern. This is not to deny the importance attached by the schemes to charity work or to corporate social responsibility, but it does illustrate the distance which the cash plans have travelled from their 'voluntary social service' roots.

Another distinctive aspect of the early continuing schemes was their claim to be patients' organisations. On the one hand this involved the retention of pre-war structures of member participation, whereby branch associations of contributors elected representatives to scheme management committees, so that grassroots opinion influenced policy. On the other, it meant the service of scheme officials on NHS bodies. The role of the schemes as a democratic forum for patients was undermined by NHS structures. These had removed agreements for scheme representation on hospital boards, much to the chagrin of pre-1948 contributors who argued that the NHS 'makes no attempt to retain as a social asset the sense of common effort . . . and . . . will destroy the existing machinery of democratic control of the hospitals'.⁵⁴ Despite such setbacks, the BHCSA consistently urged the schemes to develop relationships with hospitals and health authorities and warned that if they were seen as being concerned only with the interests of their membership they could not expect to receive a voice in NHS governance. It was noted that 60 contributory scheme members were on NHS authorities in 1970.⁵⁵ Our research suggests, however, that the elaborate machinery for democratic involvement which characterised the pre-war period has become a thing of the past. Our contacts with surviving schemes indicate that voluntary participation, for example by group secretaries, who were responsible for collecting subscriptions, has been on the wane for many years. This has been reflected in a steep decline in the numbers of members and volunteers attending annual meetings. The regulatory requirements of the Financial Services Authority, which treats HCPs as small health insurance companies, have also prompted reform of corporate governance; by 2001 the Merseyside scheme recorded that 'a revised constitution and streamlined board has allowed Medicash (as it was now known) to become more efficient and capable of making strategic decisions more quickly'.⁵⁶ The Sheffield scheme, similarly, introduced a reform of its committee structures in 1974, at the same time as it renamed itself the Westfield Contributory Health Scheme. The reason for this was that its organisational structure was now regarded as 'clumsy, bureaucratic and inefficient'.⁵⁷ The contributors' association, which had existed since 1921, was wound up; the regional committees in Barnsley, Rotherham and Chesterfield suffered the same fate, not least because they would be 'superfluous' if the new scheme was loosening its ties to South Yorkshire in a search for new business; and there was a substantial reduction in the size of the Executive Committee.⁵⁸ In both Sheffield and Merseyside, then, the scope for direct involvement of contributors or members in the operation and governance of the schemes/cash plans had been reduced.

A third example of the shifting boundary between mutualism and competition is provided by the fate of the so-called 'gentleman's agreement', under

which schemes agreed not to canvass or advertise in the territory of another BHCSA-affiliated scheme. It appears to have dated from 1955, when the BHCSA's executive committee expressed 'strong disapproval of competition between schemes and of disturbance by any other scheme "in possession" in any one contributing establishment'.⁵⁹ The self-image was of a movement which had 'eschewed cut-throat competition' and 'had tried to operate on a territorial basis unlike the provident movement'.⁶⁰ While PMI and the non-affiliates (such as The Hospital Saturday Fund in 1970) competed for business nationally, the gentleman's agreement was intended to maintain a fraternal spirit between the funds. Again, this harked back to the era of voluntary hospitals where schemes operated regionally within the catchment area of each hospital, or group of hospitals.

This concordat was bound to come under pressure when the need to boost recruitment made the maintenance of restrictive practices problematic. At the 1969 AGM the BHCSA President deplored restrictions in recruitment imposed 'by imaginary geographical considerations',⁶¹ and the meeting then terminated the gentleman's agreement with a resolution that 'the more progressive schemes may develop wherever practicable or desirable without regard to geographical location after giving due notice to and consultation with any local scheme'.⁶² This rather half-hearted acceptance of competition only led to further tensions, as in 1979 when the Worcester scheme complained that the Wolverhampton association was advertising in its area and canvassing local firms. The president explained that the terms of the gentleman's agreement were such that no scheme 'deliberately poached upon another scheme's preserve'.⁶³ Thus despite its formal termination, the spirit of the gentleman's agreement lingered on, acting as a brake on full-blooded competition. As late as the 1988 BHCSA AGM, a row developed over the plans of one of the largest schemes to hold countrywide 'roadshows'. Its assertion that EEC competition rules made the gentleman's agreement illegal was met with the protest that 'there was more than legality to consider within the movement', although in the event such objections did not carry the day.⁶⁴

Consideration of these three areas – charitable giving, democratic structures and the gentleman's agreement – therefore suggests that in order to survive it has been necessary for the schemes to divest themselves of some of the features of mutualism and voluntarism which had initially set them apart from private health insurers. Indeed, recent changes in the cash plan sector lend weight to this view. Various mergers have taken place and some schemes have been absorbed by larger cash plans, albeit continuing to operate under their historic names. The trade journal *Health Care Market News* noted in 2002 that 'the time for the smaller funds looks now to have run out' as a result of competition and the costs of compliance with regulations imposed by the Financial Services Authority (FSA).⁶⁵ The sector is now attracting interest from for-profit commercial cash plan providers, established in most cases by large general insurance companies

but with some direct involvement by high street retailers. For now, the surviving contributory schemes still account for over 80 per cent of the market, with HSA Healthcare (45 per cent) and Westfield accounting between them for 55 per cent of market share (Laing and Buisson, 2003). However, the entry of commercial organisations may erode their market position, much as was the case when commercial hospital providers moved into private hospital provision in Britain in the 1980s, largely at the expense of the undercapitalised charitable hospital sector.

Conclusions

For over 50 years the contributory schemes/health cash plans have complemented the services provided by the NHS. They initially conceived of themselves as carrying forward a tradition of voluntary sector activity, and a residue of goodwill and habit permitted the continuing schemes to retain and rebuild membership, helped by the rapid development of an attractive benefit package. This was founded on the hospital cash grant and optical and dental benefits, and these eventually came to form the core business of the schemes. The cash plans remained distinct from provident insurers, due to their philanthropic work, their representative procedures and their sense that they belonged to a movement characterised by mutualist rather than competitive values. By the 1970s, however, the ethos of the schemes was under threat. Doubts were voiced about their public profile, more business-like decision-making arrangements were adopted, the benefit side assumed greater importance than charitable work, and the territorial restrictions were gradually loosened. These changes halted the decline in membership so that by the end of the century, with some 3 million contributors, the movement enjoyed a similar level of support to that which it received in the early 1950s. However, the schemes had not succeeded in sharing in the boom which PMI had experienced in the 1970s and 1980s, and they still sought a way of tapping significant new markets for their product, while at the same time competitive pressures were exacerbated by the entry of for-profit insurers into the cash plan market.

Given these trends, where can we position cash plans in relation to contemporary debates about, and developments in the welfare state? Recent social changes such as rising prosperity, popular perceptions of the quality of public services, and the rolling-back of the state have led commentators to suggest that more of a 'pick and mix' approach to welfare may figure in the future (Klein and Millar, 1995). Diversity and consumer choice will be promoted, drawing on the public, private and non-profit sectors. There might be several reasons why cash plans would be attractive in this scenario. One reason is related to trends in the labour market towards self-employment and greater flexibility, which mean that more social risks are met individually. Cash plans offer protection against the varied costs associated with illness and would seem rational choices in these

circumstances. For companies, cash plans are also marketed as ways of minimising or externalising risks, such as those associated with short-term absences from work. Such perks may also aid recruitment in tight labour markets.

Recent debates about 'new mutualism' and 'new localism' in the welfare state are also pertinent. It is somewhat ironic that this policy discourse has emerged when some elements of mutualism in health care have largely disappeared. And within public sector services, it is not clear that consumerism extends much beyond a desire to maximise individual or family advantage (Needham, 2003). We do not have evidence on social attitudes to the surviving schemes and therefore we cannot comment on whether mutuality is important to their individual subscribers. All we can say is that there appear to be associations between trends in HCP membership and increased NHS charges, suggesting that decisions to subscribe are not just driven by rising real incomes but are a response to an awareness that the state has offloaded some of its former responsibilities.

Given that the major political parties are emphasising the role of choice and consumerism in health policy, the schemes could be well placed to benefit from the current transformation of the NHS into a regulated market. The financial regime under which the new NHS Foundation Trusts will operate gives them a financial incentive to structure provision so as to minimise the time patients spend in receipt of free, publicly-funded health care (Pollock *et al.*, 2003). Instead they will seek to discharge patients swiftly into social or intermediate care settings where means-tested charges can be levied. This may create additional scope for insurance products designed to cover the costs of convalescent or domiciliary nursing care. However, critics point out that that this could also herald the fragmentation of the NHS into a series of submarkets in which the process of caring is broken up and commodified (Leys, 2001).

At the same time as the government is opening up opportunities with one hand, other forms of regulation will affect the future development of the schemes. A tighter regulatory environment exists than was the case for much of the post-war era. The advent of the Financial Services Authority, the Financial Ombudsman and the General Insurance Standards Council has ushered in customer protection programmes. An emphasis on compliance with regulations is likely to increase the overheads of these companies and will result in more mergers and ultimately fewer and larger cash plans. Whether the notion of the 'Movement' which has obtained since the formation of the BHCSA in 1930 will survive into this commercial and regulated marketplace remains to be seen.

Notes

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- 2 BLPES (British Library of Political and Economic Science) BHCSA 15/6 'Summary of Questionnaire having regard to the forthcoming implementation of the National Health Service Act 1946', February 1948.

- 3 BHCSA Annual Report, 1950.
- 4 Westfield Contributory Health Scheme Archive, Sheffield: British Hospitals Contributory Schemes Association, 'Report of the Proceedings of the Final Annual Conference, Folkestone, 1948', p. 35.
- 5 TNA (The National Archive): PRO MH 99/37, 'National Health Service Appeals for Funds, etc', RHB (48) 41a, 18 December 1948.
- 6 *Daily Telegraph*, 12 January 1949; Ministry of Health Circular RHB (48) 25A, Appendix 1 BHCSA Circular CSA 1949.
- 7 Liverpool Archives M610 MED 2/3/2/2, correspondence of Merseyside Hospitals Council (MHC), Maxwell to B. Braddock, 6 January 1948, Bevan to B. Braddock, 27 January 1948, B. Braddock to Maxwell, 29 January 1948; 'Saturday Fund Faces Trades Union Boycott', *Birmingham Evening Despatch*, 3 September 1947; BLPES, BHCSA 18/7, BHCSA Circular CSA 49/1, 3 March 1949; Patients Aid Association (PAA), 'Executive Council Minutes of Meetings from 4.7.48 to 9.12.53', AGM, 15 April 1950; Bolton and District Hospital Saturday Council, newspaper cutting, nd, 'Bolton trades council to withdraw support'.
- 8 BLPES Archives BHCSA 3/10, John Dodd to Henry Lesser, 9 September 1948.
- 9 Liverpool Archives M610 MED 2/3/2/2, MHC, 'The Future of the Merseyside Hospitals Council', Memorandum by the Secretary, Minutes of the Revision Sub-Committee, 6 May 1947.
- 10 Merseyside Hospital Council, Annual Report, 1946, 1950, 1957.
- 11 The BHCSA (1948) annual reports began to include an analysis of benefit expenditure from 1970.
- 12 Calculated from Leeds Hospital Fund, Annual reports, by dividing income from contributors by average contributions.
- 13 This discussion is based on our analysis of annual reports of several surviving schemes; fuller details are available from the authors.
- 14 Leeds and District Workpeoples' Hospital Fund (LDHF), Annual Report, 1947, 1948, 1949; PAA, 'Executive Council Minutes of Meetings', Finance Sub-Committee, 21 February 1961.
- 15 TNA: PRO BS 6756 BHCSA (1948), 'Ninth Annual General Meeting, Manchester, Appendix 2', pp. 4–5.
- 16 BLPES BHCSA 3/12, 'Study of Hospital Contributory Scheme Statistics, 1951/52'.
- 17 TNA: PRO MH 99/94 BHCSA 'Background Notes for Minister: History of the Contributory Schemes Movement and the Association', nd. 1962, p. 2.
- 18 Letter to *The Times*, 5 May 1951.
- 19 These comments draw on an analysis of trends in NHS charges and their contribution to NHS funding by John Mohan.
- 20 PAA Annual Report 1960.
- 21 TNA: PRO MH 99/94 BHCSA 'Background Notes', pp. 3–4.
- 22 TNA: PRO MH 99/94 'Note on convalescence for the Minister's address to the conference of the British Hospitals Contributory Schemes Association, 19 October 1962', pp. 1–2; *The Hospital*, 55: 11, 1959.
- 23 *Ibid.*, pp. 2–3; Liverpool Archives M610 MED 2/3/2/2, 'The Future of the Merseyside Hospitals Council', May 1947.
- 24 LDHF, 1955, 1974.
- 25 BLPES BHCSA 18/9, BHCSA Convalescence and After Care Sub-Committee Report, Appendix 3 to Circular CSA 61/1, 1961.
- 26 MHC, Annual Report, 1966.
- 27 TNA: PRO MH 99/94 'Note on convalescence', pp. 3–5.
- 28 BHCSA Annual Reports, 1969/70, 1973/74, 1982/83.

- 29 Minutes of the 19th BHCSA AGM, Russell Hotel London, 3 and 4 November 1967, Westfield, Sheffield.
- 30 *Health Care Market News*, various dates.
- 31 Scheme statistics are compiled from: BLPES BHCSA 18/7 'Thoughts Engendered by a Study of Hospital Contributory Scheme Statistics 1951/52', BHCSA 3/12, AGM 1955, 'Hospital Contributory Scheme Statistics 1953/54', BHCSA 18/8, 'The State of the Movement: Hospital Contributory Scheme Statistics 1954/56', Appendix to CSA 57/3, p. 33; Reports of BHCSA AGM 1956; 1982, 1988; BHCSA 18/9, J. Dodd 'Summary of the State of the Movement 1962: Popularity of Benefits', BHCSA Annual Reports, 1950–1981, 1987/88; Laing and Buisson, 2003; PMI: Office of Health Economics, 2001.
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- 38 BHCSA Annual Report 1971/1972.
- 39 BHCSA Annual Report 1970/1971, 1974/1975.
- 40 BHCSA Annual Report 1979/1980, 1980/1981.
- 41 BHCA Executive Committee Minutes, 14 December 1989.
- 42 BHCSA Annual Report 1968; Liverpool Archives, MHC, M610 Med 7/1/4.
- 43 WCHS Annual Report 1974.
- 44 BHCSA AGM 1965, J. N. Briscoe.
- 45 BHCSA Minutes of the 17th AGM Southport 1965.
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- 48 See www.hsa.co.uk.
- 49 BHCSA AGM Minutes 7 October 1967. Statutory Instrument No 1552 classified contributory scheme business as 'General' from July 1978, BHCSA AGM 1977, BHCA Garforth, Leeds.
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- 56 Medicash, Annual Report 2001.
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- 60 BLPES, BHCSA 18/10, BHSA circular CSA 2/67.
- 61 President of BHCSA Sir Archibald MacDonald Gordon, BHCSA Annual Report 1969/1970.
- 62 Resolution at 1969 BHCSA Conference, BHCSA Annual Report 1969/1970.

- 63 BHCSA Minutes of the Executive Committee 28 February 1979, BHCA Garforth, Leeds.
 64 BHCA Archive, Garforth, Leeds, BHCA Executive Committee Minutes, 14 April 1988.
 65 *Health Care Market News*, VI(x), Aug.–Sept.2002, p. 35.

Acknowledgements

We gratefully acknowledge financial support from the ESRC, award reference RES-000-22-0044, and from the Leverhulme Trust. An earlier version of the paper was presented at the conference 'Hospital Contributory Schemes to Health Cash Plans', held at the Institute of Historical Research, London, October 2003, and we thank participants for their comments. We are particularly grateful to Calum Paton and Nick Mays for their helpful advice. We also acknowledge the cooperation of the officials of various surviving schemes for granting access to archival material, although the views expressed are our responsibility alone.

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