

SUPPLEMENT

TALKING POINT

Philanthropic organisations and the NHS

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Philanthropic organisations are important to ensure innovation, flexibility, and responsiveness in the Health Service. This may be seen by comparing activities in the United States and the United Kingdom.

Before reorganisation local authorities could supplement central finance from their own revenue. The chief advantage so far as the Health Service was concerned was that progressive local authorities could innovate new forms of delivery of care. But now there is virtually total dependence on central government finance.

There were disadvantages to the previous system. The main one was that priorities for health as against other services differed and there was great variation in per capita expenditure. Furthermore, not every local authority perceived nationally agreed objectives as priorities within their own total needs—for example, the development of health centres. Some authorities had not only failed to build any health centres before 1974 but also in their thoughts for the next 10 years had no plans to do so. Where innovations in health care required health workers to extend their work it was usually not difficult to reach agreement on the new responsibilities and arrange the appropriate training programmes.

Resource allocation

We have known for some time that per capita expenditure for hospital care varied greatly throughout England and Wales. When Secretary of State, Richard Crossman was responsible for introducing a formula which, using incremental funds, would have equalised the distribution of capital and revenue to regional hospital boards by 1980. With reorganisation it was possible to start comparing the expenditure of all health care to populations smaller than the 15 regional hospital boards—the 90 area health authorities.

The Resource Allocation Working Party¹ interpreted its terms of reference as being to secure, through resource allocation, that there would eventually be equal opportunity of access to health care for people at equal risk. The working party was concerned with the distribution of funds which are used for the provision of real resources and not with the way the resources are deployed. Instead of the old practice of submitting specific proposals to justify extra funds area health authorities would receive their fair share of the national total which they could spend in whatever way they thought best, subject to central guidelines on the national policies and priorities.

The DHSS's consultative document, *Priorities for Health and Personal Social Services in England*,² collates previous "norms" or yardsticks for the level of provision for many services. The guidance includes facilities—beds, day hospitals, and staffing ratios—often in a specific way. Most of these guidelines have been drawn up based on national utilisation data but with much subjective overlay. There are little objective data available that can provide health policy makers with specific guidance on which to base the need to services. Until there is, it would be more appropriate for the Government to draw up criteria for levels of service within which health authority planners had room for manoeuvre. The whole planning process from the health care planning teams upwards is unlikely to achieve its purpose if the planners' function is purely to relate existing levels of service to the specific national yardsticks.

DIFFERING NEEDS

It is commonsense that even adjacent health authorities with similar age structure may have different health service needs because of social, cultural, psychological, environmental, and other factors. Elderly people living in a community with extended family structures will be able to remain in the community longer than in a new town area where the nuclear family is the typical picture. In the former case a health authority may think it wise to invest over and above the recommended yardstick in services which support the family at the expense of inpatient geriatric beds. The latter might be provided at half the nationally recommended level.

The level of local authority services—sheltered housing or voluntary societies availability—will also be a critical factor in determining what health care planning teams think should be the right balance of services. Enthusiasm will disappear rapidly if flexibility cannot be built into the planning process and

decision making at district level. Any health service must constantly be evolving and experimenting with new forms of delivery of care. But it is difficult to see how there can be such changes in our new structure.

Philanthropy in the USA

"There are 26 000 foundations within the United States and their purposes are as multiple as the colours in the pied coat of the piper, ranging from the care of stray cats to something grandiloquently amorphous as the Rockefeller Foundation's charge to promote the well-being of mankind throughout the world."

In a paper looking at the trends in foundation speaking vis à vis the Federal Government's expenditure, Koleda³ describes how historically private philanthropy has supported activities, institutions, and purposes within the frameworks of national goals and values but outside the pale of government operations. In the 1930s philanthropic expenditures in support of health and health-related activities nearly equalled the combined expenditures of the Federal Government's health programme. In the 1970s philanthropic health spending has declined to about one-seventh of that of the Federal Government. In 1973 foundations allocated an estimated 626 million dollars, or 31% of their budgets, to health and health-related activities.

When we compare how the money is spent it is clear that the foundations' job is still important, despite their diminishing financial influence. While federal expenditure for the direct financing and provision of services dwarf those of foundations, the latter are prominent in projects to improve the organisation and delivery of health care. Koleda sums it up by saying that foundation expenditures flow towards investment in the health care system of tomorrow and federal outlay towards consumption of services today.

Charitable giving in the UK and USA* in 1973

Sources of gifts	UK			USA		
	Total giving (£m)	Per caput (£)	Health and welfare (£m)	Total giving (£m)	Per caput (£)	Health and welfare (£m)
Living individuals	140	2.54	45	7567	37.46	—
Legacies and bequests	65	1.18	25	1275	6.31	—
Companies	35	0.63	10	396	1.96	—
Charitable trusts	140	2.54	34	983	4.87	—
Total	380	6.90	114	10221	50.6	3884

*Converted to £, based on \$2.40 to the £.

SUPPORT FOR RESEARCH

Blendon⁵—from the Robert Wood Johnson Foundation, which since 1972 has contributed 219 million dollars to improve health care in the United States—has identified other reasons why philanthropic organisations should continue to play an important part in health care. "Venture capital" and support for experimentation in the areas of research, education, and health services delivery will remain important functions which can be developed quicker than government service because of the consultation the Government must necessarily undertake.

At a time when there is overriding concern about the rising costs of medical care governments may ignore the need for constant improvement in standards. Philanthropic organisations will have a positive job to ensure that there is no let-up in advancing knowledge or raising the quality of care. Finally, Blendon refers to the growing concentration of authority by the government over the country's health services financing and the need for independent monitoring of public sector activities in health.

Philanthropy in the United Kingdom

It is impossible to obtain accurate totals of charitable giving in the United Kingdom. The Wells International Donors Advisory Services Ltd, which is a division of the Wells fund raising group of companies in the UK, has assumed the responsibility for compiling data similar to those available in the United States. They estimate⁶ that in 1973 the total amount given was around £380 million, of which £140 million was given by charitable trusts. The data for the latter is more accurate since the Charities Aid Foundation Directory is compiled from information received from most charitable trusts.

The table shows how charitable giving in the United Kingdom compares with the United States. Total giving in the United States is equivalent to over £50 per head, or 2% of their gross national product, as against £6.90 per head in the United Kingdom, or about 0.5% of our GNP. Individuals in the United States give 15 times more per caput than in the United Kingdom, but the differences between the two countries in relation to companies and charitable trusts are less appreciable. Though the percentage of the total spent on health and welfare between the UK and the USA is not too dissimilar (30% as against 36% in 1973), in per caput terms the differences are vast, being £2.07 in the UK and £19.25 in the USA.

HEALTH AND WELFARE GIVING

Out of the 100 largest fund-raising charities in the United Kingdom, 33 are concerned with health and welfare giving. In fact, the two largest fund-raising charities support health activities: the Imperial Cancer Research Fund and the Cancer Research Campaign. All but one of the 33 are concerned with specific diseases, such as cancer and multiple sclerosis, or categories of handicaps such as arthritis or the physically handicapped. The exception is the King Edward VII Hospital Fund, which received gifts and legacies of £180 000 in 1973. The National Society for Autistic Children is 99th in the league table, with gifts and legacies amounting to £37 000; this contrasts sharply with the £4.4 million for the Imperial Cancer Research Fund.

Many charitable trusts are established by individuals or companies. These are not dependent on public support and are freer to grant funds for a wider range of activities, including studying issues such as Government policy in social and other affairs and the audit of public service organisations. The Rowntree Trust, the Nuffield Foundation, and the King Edward Hospital Fund are three of these trusts.

The above figures do not include non-profitmaking bodies that are not charities, or grants to relevant Government research councils—the Medical and Social Science Research Councils and the Health Education Council.

Conclusions

Undoubtedly the views advocated on the way forward for philanthropic organisations in the United States also cover functions which need to be performed here. The Nuffield Provincial Hospitals Trust and one or two other foundations, are doing excellent work but we need more participation in the sort of functions that Blendon outlined. This will require much more money and effort than is currently spent in the United Kingdom.

A royal commission on health cannot be set up every year and yet it is obvious that to study a cross-section of the service at a point in time is no substitute for a continuing review. Royal commissions are unable to undertake anything other than short-term research or investigation and inevitably they throw up hypotheses which warrant further investigation. We now have a highly centralised service with complete control by the Government on the finance and almost complete control on the priorities which determine expenditure. There has never been a greater need for independent outside influence.

References

- ¹ DHSS, *Sharing Resources for Health in England*. London, HMSO, 1976.
- ² DHSS, *Priorities for Health and Personal Social Services in England*. London, HMSO, 1976.
- ³ Knowles, J, *New England Journal of Medicine*, 1975, **292**, 972.
- ⁴ Koleda, M. S., *Foundation News*, July-August 1975.
- ⁵ Blendon, R. J., *New England Journal of Medicine*, 1975, **292**, 946.
- ⁶ Wells Organisation Ltd, *UK Charity Giving Reports*, 1973.

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In brief . . .

Royal Commission: BMA evidence

There was a special meeting of the BMA Council on 22 December to consider the initial draft of the association's evidence to the Royal Commission on the NHS. Six panels had dealt with separate aspects of the evidence: organisation and administration; finance; future health patterns; manpower and staffing; medical education and research; and relationship of the profession to state service. The Association's Royal Commission Evidence Working Party correlated the evidence at a two-day weekend meeting in December. The Council will meet again on 12-13 January to approve the final draft which will be published in the *BMJ* on 29 January. A Special Representative Meeting will be held on 9 March when representatives of BMA divisions will consider the evidence.

Medical teachers: revised structure

The BMA's Full-time Medical Teachers and Research Workers Committee met on 21 December to discuss representation of this section of the profession, including a revised structure for the committee. The members approved in principle a Medical Academic Staff Committee to act for "medically qualified full-time personnel" employed by a university, the Medical Research Council, or an institution engaged primarily in medical research employing staff on university-linked pay scales. The committee will be formed of 12 representatives to the Representative Body, of whom six shall be clinical and

six preclinical; four other members from a conference of academic representatives, of whom two shall be clinical and two pre-clinical. There will be cross representation with the CCHMS and HJS Committee. The MASC will meet at least twice in each session, delegating to clinical and pre-clinical subcommittees work that is their sole concern: for example, salaries and terms and conditions of service for clinical academic staff will be the responsibility of the clinical subcommittee. It is planned to convene a conference of academic representatives—at least every year—comprising, so far as is practicable, representatives from each clinical and pre-clinical place of work. The Association of University Clinical Academic Staff was represented at the meeting by four members, and the BMA and AUCAS will jointly be contacting academic and research staff in the near future.

GMSC discusses hospital practitioner grade

At its meeting on 16 December the General Medical Services Committee discussed the hospital practitioner grade and the CCHMS's call to widen its scope (18 December 1976, p 1518). The meeting resolved: "(1) that the hospital practitioner grade (GP) already agreed should be implemented without prejudice; and (2) that the hospital practitioner grade (non-GP) should be negotiated on comparable terms as soon as possible." A report on the meeting will be published in a future issue.