

---Page 1: Title Page---

Title:

More on Paper than in Practice? The ‘Transformation’ from NHS to Charity Hospital

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---Page 2: Abstract---

Title:

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Summary (149/150 words):

During the 1980s and 1990s, nine hospitals in England transferred out of the National Health Service (NHS) and into charitable control. By exploring 30 years of financial records, annual reports, and contemporary materials, this paper examines how these hospitals have evolved since their transfer. Framing insights using Resource Dependence Theory, connections are identified between how these organisations are resourced and their development: these hospitals’ funding sources have shaped their organisational mission, scale and scope of services, and building developments. The institutional change from NHS to charity hospital appears more on paper than in practice: public funding continues to be their dominant source of income and, despite no longer being subject to NHS restrictions over the use of charitable funds, these hospitals continue to mainly use charity to fund ‘extras’ rather than core services. Findings question the public benefits of funding these hospitals outside of, rather than in, the NHS.

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Introduction & Background

Between 1984 and 1999, nine hospitals in England transferred out of the UK’s National Health Service (NHS) and into charitable control (Mohan & Gorsky, 2001). These cases are unusual and stand out in NHS history – there are more than 1,000 NHS hospitals across the UK and these nine are the only ones known to have made such a transition. Despite their uniqueness, to date, there has been no dedicated study examining these hospitals and how they have fared since transferring out of the NHS. Addressing this, this paper explores the paths taken by these organisations since their transition, particularly how they have acquired resources. Framing analysis with Resource Dependence Theory, connections are drawn between the development of these hospitals – in terms of evolution of mission, changes in scale or scope of services, and building expansion – and how they have been resourced.

The nine hospitals examined in this paper are: Tadworth Court (now The Children’s Trust), Hoylake Cottage Hospital, Tarporley and District War Memorial Cottage Hospital, Mildmay Mission Hospital, Holbeach and East Elloe Hospital, Brackley Cottage Hospital, Tetbury Cottage Hospital, Rye, Winchelsea and District Memorial Hospital, and Odiham Cottage Hospital (Mohan & Gorsky, 2001). The initial establishment of each of these hospitals presents a similar story: all were established before the NHS as ‘voluntary hospitals’, founded by local initiative using funds from significant legacy gifts and community fundraising.

Like other voluntary hospitals, prior to the establishment of the NHS these organisations relied on a mix of philanthropic contributions including donations, legacies, and gifts-in-kind (e.g. furniture, food, equipment), alongside income from investments, contributory schemes, and means-adjusted patient fees (Mohan, 2002). This income profile changed considerably over time – though initially founded and funded almost solely through donations, by the 1930s, income from contributory schemes often exceeded donations as taxes rose and public sentiment shifted away from charitable giving (Mohan & Gorsky, 2001). Over-reliance on particular sources of income left voluntary hospitals financially vulnerable. For example, as reliance on contributory schemes increased, hospitals became increasingly exposed to variations in workers’ income and – therefore – their contributions (Mohan, 2002). By the 1940s, many voluntary hospitals were struggling to attract sufficient and sustainable income. Alongside these financial difficulties, the charitable founding of voluntary hospitals also led to uneven patterns of distribution across the UK: provision of services tended to align more with resource availability and public will to establish a hospital rather than the need within the community for such an institution (Gorsky, et al., 1999). As summarised by Abel-Smith (1964: 405), far from being needs-based, hospital distribution depended on “the donations of the living and the legacies of the dead”.

Along with most other hospitals at the time, the nine institutions we examine all joined the NHS upon foundation of the Service in 1948. At least two of the hospitals considered asking to remain independent of the NHS though both concluded doing so would be financially unviable. In 1947, the Chairman of Rye Hospital stated, to the agreement of the Board, that: “he could not see how the Hospital could go on without the voluntary subscribers, whom he

anticipated would fall off altogether in the next few years” (Rye Board, 1947). The Mildmay Hospital Council (Mildmay Council, 1946) came to similar conclusions: “In any case the general feeling of the Council was that it would be impracticable to maintain this hospital in its present form outside the National Scheme.”. Like other NHS hospitals, post-1948, all nine of the hospitals we examine were funded by the state and managed under newly established Regional Hospital Boards. The role of charitable effort in hospital provision was not eliminated though it was significantly reduced: as all core hospital expenses would be funded publicly, charitable contributions were to be limited to surplus contributions such as patient amenities and medical research (British Hospitals Association, 1948).

Half a century later, these hospitals returned to charitable control: facing closure, the communities surrounding each of the nine hospitals rallied to take on the management, and in some cases the ownership, of ‘their’ hospital under purposely-established charitable trusts. Their transfer from state to charitable control came amidst growing support from Conservative governments for voluntary interventions in the health sector. Through the Health Services Act 1980, the Conservatives enabled NHS bodies to actively fundraise for the first time; and they explicitly expressed interest in transferring control of hospitals to voluntary bodies to avoid hospital closures (Jenkin, 1979). A growing chorus of policy proposals from generally right-leaning think-tanks argued that transferring control to voluntary bodies would both unlock other funding sources beyond state provision, such as local fundraising and private patient fees, and afford those organisations the ability to innovate and respond more rapidly to changing needs outwith the bureaucratic confines of the State.

Since their transfer back to charitable control, questions remain regarding how these hospitals have evolved, including how their activities and development compare to those before the NHS and during their NHS era. To this end, we examine (a) how these hospitals have attracted resources since their transfer to charitable control, and (b) how these resource-acquisition strategies have shaped their development. In so doing we critique the two key claims made in support of their transfer. This paper contributes: extensive empirical analysis of nine previously unexplored hospitals which stand out in the UK healthcare landscape; theoretical development of Resource Dependence Theory within the nonprofit sector; and conceptual insights to wider debates regarding the strengths and limitations of charitable provision of healthcare services.

This paper proceeds first by examining Resource Dependence Theory and the contributions it makes to our analysis. Second, the multi-case study approach and mixed methods of data collection used are explained. Third, findings are presented, distinguishing between four main sources of income for the hospitals examined: income for hospital activities; charitable income; investment income; and other income. Across these, we examine how different sources of income have been used by the hospitals, and how this has shaped their development since transfer. Finally, these findings are discussed in relation to Resource Dependence Theory and debates on charity hospital provision. We find that whilst on first inspection it would appear these hospitals have returned to their pre-NHS status of voluntary hospitals, reliant predominantly on charitable contributions, in practice they continue to function and be resourced much as they were whilst they were in the NHS: public funding remains their dominant source of income, while charitable contributions are used predominantly to fund ‘extras’ not provided by the NHS.

Resource Dependence Theory

We frame our analysis in this paper using Resource Dependence Theory (RDT). RDT essentially posits that organisations need resources to survive (Malatesta & Smith, 2014; de los Mozos et al., 2016). The success of an organisation therefore depends on its effectiveness at acquiring resources. Resources are both tangible and intangible, including for instance financial, human, and information (Doyle et al., 2016). Resources are obtained from the environment in which an organisation operates – including other organisations (Berrett and Holliday, 2018). There are three characteristics of the environment in which any organisation operates, and from which organisations acquire resources: concentration of power, scarcity of resources, and interconnectedness of organisations (Malatesta and Smith, 2014). The process of resource acquisition creates a relationship between resource providers and resource seekers characterised by power and dependence: those who have resources are in a position of power over those seeking resources from them; resource seekers are dependent on resource providers (de los Mozos et al., 2016; Pfeffer & Salanik, 1978). Resource scarcity can threaten the survival of an organisation, especially if that resource is critical (Froelich, 1999). Dependence on others for resources hence creates uncertainty for organisations and it is the role of organisation managers to manage these dependencies and reduce uncertainty (Malatesta and Smith, 2014).

All nine of the hospitals examined in this paper transferred to the control of charitable trusts, becoming non-profit organisations (NPOs). How NPOs are resourced matters significantly as it shapes their outcomes and operations – that is, their ability to achieve their mission and how they go about doing so (Doyle et al., 2016). In particular, because of the power-dependence relationship established with resource providers, NPOs may align their spending behaviours with the priorities of their largest funders (Leone & Van Horne, 2005). Accordingly, there are two dominant questions for researching NPOs using an RDT perspective: where do they acquire resources from; and what strategies for resource acquisition do they use (i.e. diversification or concentration)?

Resource Sources for NPOs

There are four primary resource sources for NPOs: donations, government, private, and investments. Each are examined below.

Donations

The traditional ‘cornerstone’ of support for NPOs has been and remains donations (Froelich, 1999). NPOs can receive donations from individuals and institutions (Leone & Van Horne, 2005). For example, prior to the establishment of the NHS, voluntary hospitals were supported with donations and legacies from members of the local community, and by various organisations including local groups (e.g. schools, churches) and larger grant-making bodies (e.g. The King’s Hospital Fund for London). Donations were not just financial but also in-kind support – material contributions that can be convertible into money (e.g. clothing, books, furniture) (Gray, 2007). Though charitable contributions continued after 1948, they significantly reduced given the responsibility for providing clinical services then lay with the state.

Charitable funding for NPOs can alleviate pressure on state resources, and be used to fund ‘riskier’ and less prominent initiatives such as research into less ‘popular’ health conditions. However, because donations are voluntary, they have been criticised as inherently insufficient – charity will never be large enough to address social issues alone (Salamon, 1987). Donations are also unstable as an income source, varying with economic climate and public sentiment, making it challenging for NPO managers to plan for (Rooney, 2007). Whereas government funding is at least in theory based on need, charitable funding is driven more by emotional ties and the wishes of the donor (Bekkers & Wiepking, 2011). Consequently, some causes and organisations (e.g. hospitals supporting children, cancer-related charities) are more successful than others in attracting donations (YouGov, 2022). Donations further tend to be parochial, primarily benefitting donors’ own communities (Lattimer, 1994). Given some communities are more affluent – and therefore more able to give charitably – than others, this risks reinforcing inequalities in access to services, as evidenced by the uneven pattern of hospital distribution prior to the NHS (Gorsky, et al., 1999).

Government Funding

NPOs, including charity hospitals, receive support from government through multiple channels, including direct funding in the form of grants and contracts for services, and indirect funding through tax relief (or favourable tax rates). Broadly speaking, government funding for NPOs is considered more stable than charitable income, and viewed as necessary in many cases to avoid ‘voluntary failure’ (Malatesta & Smith, 2014; Salamon, 1987). Dependence on government funding can provide the stability needed for an NPO to grow in both scale and legitimacy (Froelich, 1999; Doyle et al., 2016). However, reliance on government support can also reduce organisational autonomy (Bernstein, 1991), create bureaucratic pressures to change operations (Froelich, 1999), and ultimately lead to mission drift (Malatesta & Smith, 2014). Over-dependence on government funding can also reduce an NPO’s ability to adapt to social needs (Anheier et al., 1997; Verschuere & De Corte, 2014; Doyle et al., 2016). Concerns have further been raised that public funding for NPOs ‘crowds out’ (i.e. disincentivises) donations – potential donors view voluntary contributions as less needed if that NPO receives significant government support (Rooney, 2007). Given these possible trade-offs, dependence on government funding has been described as a “double-edged sword” (Jung & Moon, 2007: 206).

Since the establishment of the NHS (Lambert & Mohan, Forthcoming) but particularly since the 1980s, the UK government has contracted out some NHS services to independent healthcare providers, enabling NHS patients to be treated in more hospitals (Morris, 2007). Government’s own reliance on independent providers to provide NHS services has been described as creating “a symbiotic relationship”, leading to interdependence between organisations rather than dependence of just one on the other (Doyle et al., 2016: 1874).

Private Fees

Despite being NPOs, charity hospitals can receive income from fee-paying patients (Morris, 2007). Relative to donations and government support, fees are typically a much smaller but increasingly important sources for NPOs: there is growing pressure on NPOs to broaden their funding base beyond donations and embrace commercial opportunities viewed as a sustainable income source. However, charging fees for hospital services is inherently exclusionary as not everyone is able to pay. Debates have therefore emerged over whether governments should subsidise private medicine and whether private hospitals should be eligible for charity status (e.g. Charter & Frean, 2004).

Investments

Charity hospitals have relied on investment income since their origins in the 18th and 19th centuries. Investment income – such as bank interest, returns, and capital gains – is typically a small source of income for NPOs, amounting to less than 1% of total income (Bowman et al., 2007), but can be a significant source for a minority of charity hospitals (Bai et al., 2020). Investment income allows NPOs to build their endowments and safeguard against economic uncertainty. Debates remain over the appropriate balance between saving for the future (through investing rather than spending resources) without ‘short-changing’ current needs (Bowman et al., 2007).

Diversification Versus Concentration of Resources

As well as the relative merits of particular sources of resource, RDT has also been used to examine the different strategies of resource acquisition adopted by organisations – specifically diversification and concentration (Malatesta & Smith, 2014). Diversification refers to the use of multiple funding sources, and types of income; concentration refers to the reliance on a single or only a few funding sources. Proponents of the diversification strategy argue that diversifying an organisation’s funding base reduces dependence of the organisation on others, thereby lowering uncertainty and exposure to financial risk (e.g. Barrett & Holliday, 2018; Kearns, 2007). However, proponents of the concentration strategy argue that reliance on fewer different funding sources reduces time and costs spent on administration, maintaining focus on and legitimacy of the organisational mission (Carroll and Stater, 2008; Shon et al., 2018).

Research findings in this area have so far been mixed. For instance, de los Mozos et al. (2016) found support for the concentration strategy as increased diversification can reduce fundraising and increase administrative costs. In contrast, Barrett and Holliday (2018) found support for the diversification argument: NPOs with a more diverse funding base faced greater stability and lowered financial risk, whereas concentration left NPOs more exposed to financial downturns. Examining the history of the Mater Misericordiae University Hospital in Ireland, a charity hospital, Doyle et al. (2016) found that the hospital’s ability to expand came from its dependence on a narrow supply of resources which did not compromise the hospital’s mission.

Using an RDT perspective in this paper, we examine the nine hospitals which transferred from state to charitable ownership in the UK. We investigate (a) how they have acquired, and continue to acquire, resources now they are no longer guaranteed public funding, and (b) how this has shaped their development over time, including their organisational mission and activities.

Case Study Methodology

Case Selection

This paper adopts a case study methodology, chosen for its suitability when exploring and explaining the complexities of a particular phenomenon over which the researcher has little to no control (Alpi & Evans, 2019; Rashid et al., 2019). In so doing we follow a similar approach to that taken by Doyle et al. (2016) in their investigation of an Irish charity hospital from an RDT perspective. Whereas Doyle et al. (2016) focus on a single case (the Mater Misericordiae University Hospital), this paper examines nine cases. By exploring multiple cases, we are able to compare and contrast the experiences of all nine former voluntary hospitals known to have transferred from the NHS back to charitable control, investigating the extent to which their evolution post-transfer has been similar to or different from one another (Yin, 2018). The nine hospitals we examine were first identified by Mohan and Gorsky (2001) – since their publication, no other former voluntary hospitals have reverted from NHS to charitable control.

Data Collection and Analysis

In a case study approach, cases are examined using multiple data sources to enable investigation of inherent complexities and provide validity in the research process (Johansson, 2007; Cresswell, 2018; Alpi & Evans, 2019). In this paper, we collected and analysed archival records, news coverage, contemporary websites, and financial statements (Table 1).

Table 1: Example data sources examined in this study.

Data type	Examples	Search & Identification Method
Archives	Hospital archives including annual reports, meeting minutes, correspondence with local authorities.	Searched all known variations of the hospital name in The National Archives <i>Discovery</i> search engine, and in archives local to the hospital.
News coverage	Reports in local and national news and newspapers about the hospital, such as fundraising events.	Searched all known variations of the hospital name in <i>The British Newspaper Archive</i> and in <i>Google News</i> .
Contemporary websites	Hospital website, JustGiving page.	Examined every primary and secondary navigation tab on hospital’s own website (excluding ‘contact us’ page and staff profiles).
Financial records	Annual reports and statement of annual returns.	Available through Companies House and Charity Commission. The most recent full financial year available at the time of data collection was for year-ended March 2021.

Quantitative data was gleaned from examining all available financial statements for the nine hospitals examined, accessed through Companies House and supplemented with insights from the Charity Commission. Financial data was available for seven of the nine hospitals: Odiham has only produced small company accounts with no information on income scale and/or

sources; Brackley closed in 2015 and reopened under the NHS in 2020 – its financial accounts are therefore no longer publicly available. Quantitative financial data was downloaded from Companies House and Charity Commission and input into a Microsoft Excel spreadsheet. All data was adjusted for inflation using the GDP deflator to 2021 prices (Gov.uk, 2022).

Qualitative insights were gathered through examining the annual reports published alongside financial statements. These typically included: reflective statements from the hospital Director; summaries of key fundraising activities from the year; and information over how income sources were spent. Contemporary online platforms – primarily hospital websites – and archival records from the hospitals’ histories were further examined for each case. Together, these shed light on the funding strategies employed at each hospital since their transfer to charitable control. Qualitative data was inductively coded and analysed using a thematic approach (Guest et al., 2012).

A summary of the nine cases examined and the data sources analysed for each is provided in Table 2.

More on Paper than in Practice? The ‘Transformation’ from NHS to Charity Hospital

Table 2: Summary of cases and data sources examined. Cases listed in order in which they transferred out of the NHS.

Hospital	Location	Year opened	Year of transfer	Current status	Archives documents	News articles	Websites	Financial records ¹
Tadworth Court (now The Children’s Trust)	Tadworth, Surrey	1929	1984	National specialist centre for children with brain injuries.	45	36	50 tabs on Hospital website	1994-2021
Hoylelake Cottage Hospital	Hoylelake, Wirral, Merseyside	1905	1984	Nursing home providing domiciliary care and day centre	-	100+	17 tabs on Hospital website; JustGiving page	1997-2021
Mildmay Mission Hospital	Bethnal Green, London	1877	1985	Specialist care and rehabilitation for people living with HIV, and rehabilitative care for homeless people	108	17	15 tabs on Hospital website	1994-2021
Tarporley & District War Memorial Cottage Hospital	Tarporley, Cheshire	1919	1987	Provides inpatient and intermediate care for elderly	21	38	12 tabs on Hospital website	1988-1992, 1994-1996, 1999-2021
Holbeach & East Elloe Hospital	Holbeach, Lincolnshire	1906	1988	Nursing care home	-	68	12 tabs on Hospital website	1994-2019
Brackley Cottage Hospital	Brackley, Northamptonshire	1876	1990	Closed in 2015; reopened in NHS in 2020 as community hospital	23	100+	6 tabs on 2020 Trust website	None available
Tetbury Cottage Hospital	Tetbury, Cotswolds	1868	1992	Hospital providing outpatient-only services	39	100+	20 tabs on Hospital website	1994-2021
Rye, Winchelsea & District Memorial Hospital	Rye, East Sussex	1919	1995	Provides intermediate, short-term care and rehabilitation for patients leaving acute hospitals	12	14	11 tabs on Hospital website	1994-2021
Odiham Cottage Hospital	Odiham, Hampshire	1910	1998	Contractor of community services	5	100+	5 tabs on Hospital website	None available

¹ Full financial years available (dates based on financial year-end).

Findings

Total Annual Income

For most of the hospitals examined, total annual income has gradually increased since their transfer to charitable ownership at a rate exceeding inflation (Figure 1, 2). Annual income growth was most rapid for Tadworth, which experienced a growth from £9.5 million² in 1994 to over £28 million in 2021. By comparison, no other hospital examined had an income above £5 million in 2021. This pattern of growth generally reflects the growing cost of healthcare provision stemming from advancing technologies, increased life expectancies, and caring for more complex health conditions.

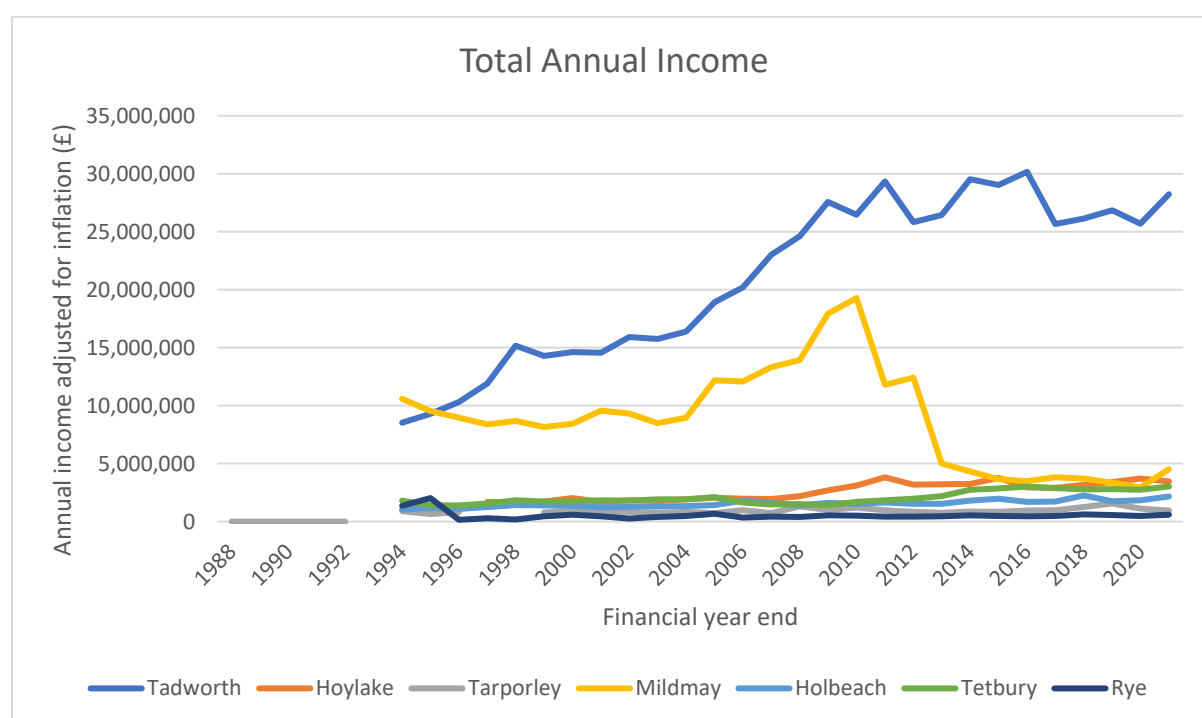


Figure 1: Total annual income.

² This and all figures provided are in 2021 prices.

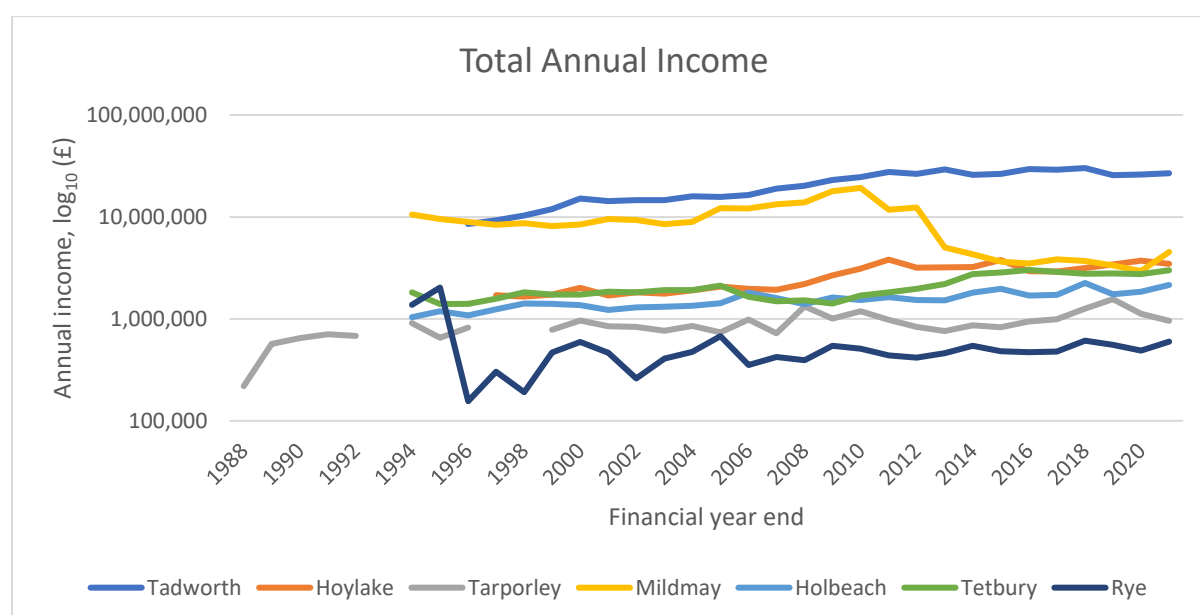


Figure 2: Total annual income (log scale).

Notably, Mildmay’s annual income fell between 2010 and 2016, after experiencing a rapid rise between 2004 and 2010. This was driven mainly by fluctuations in government funding for international aid: as an HIV/AIDS specialist, Mildmay provides services in the UK and developing countries – government funding (from both the UK and international governments) for the latter substantially fell in the aftermath of the 2008 global financial crisis and 2008 Kenyan crisis.

The hospitals examined receive four main types of funding: income for hospital activities; charitable income; investment income; and other income. In the following sections we explore the scale, sources, and uses of each of these income types.

Income for Hospital Activities

Income received for hospital activities (referred to on financial statements as ‘Charitable activities’ or ‘Activities in furtherance of the charity’s objectives’) concerns all income received solely for the delivery of the hospital’s services, i.e. patient treatment and care (Figure 3, and 4). In every case, this is typically by far the largest source of income for these hospitals: in 2021, income for hospital activities accounted for more than 60% of annual income for all seven hospitals for which financial data was available (Figure 5). For three hospitals – Hoylake, Mildmay, and Tetbury – it was more than 90% of total income.

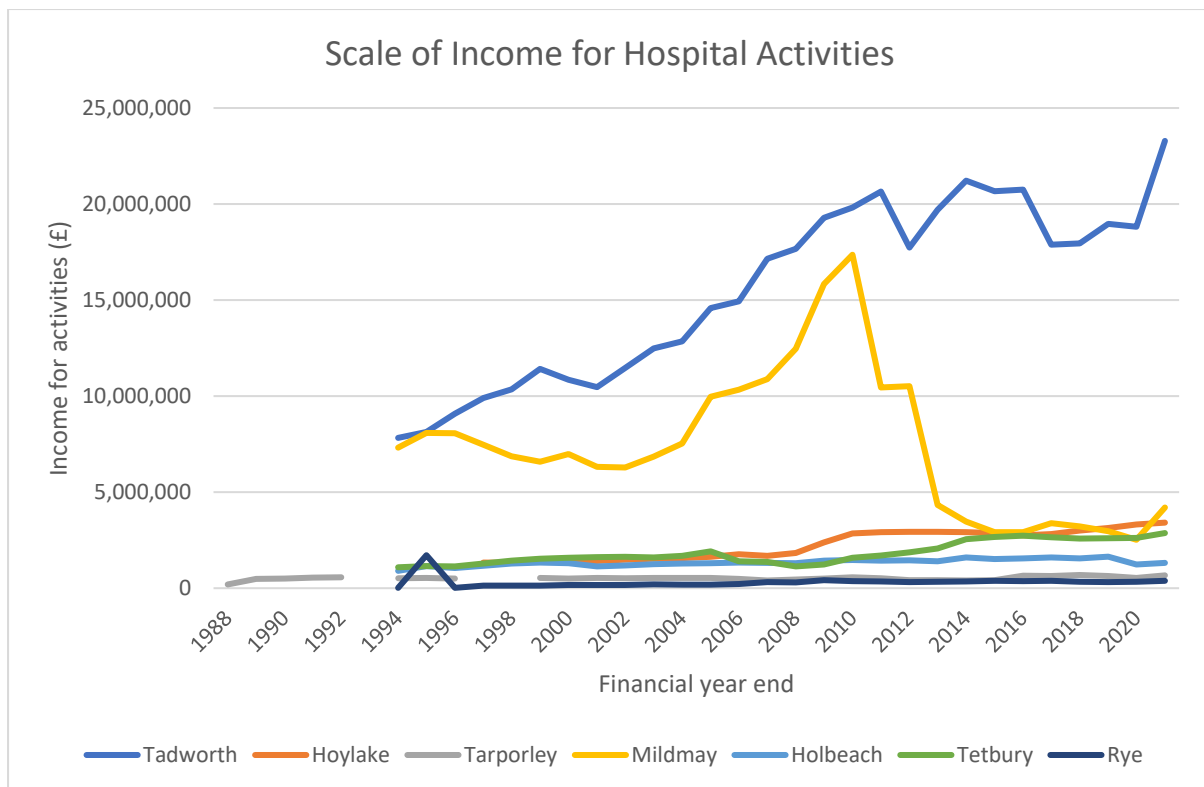


Figure 3: Scale of income for hospital activities.

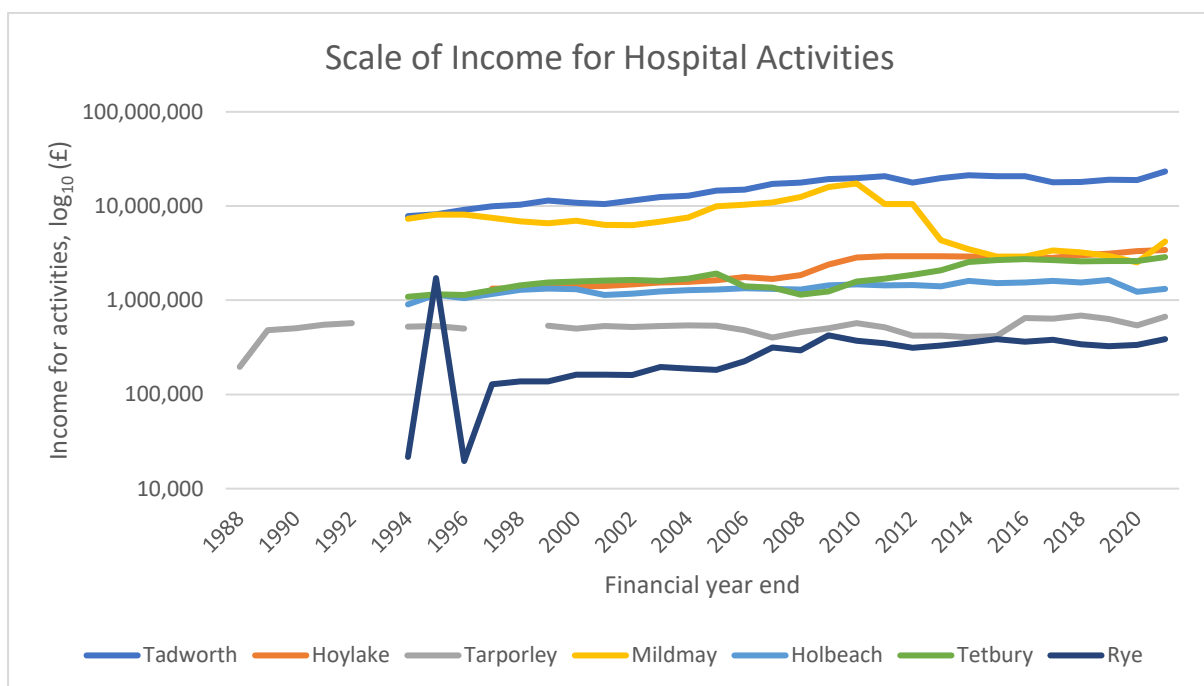


Figure 4: Scale of income for hospital activities (log scale).

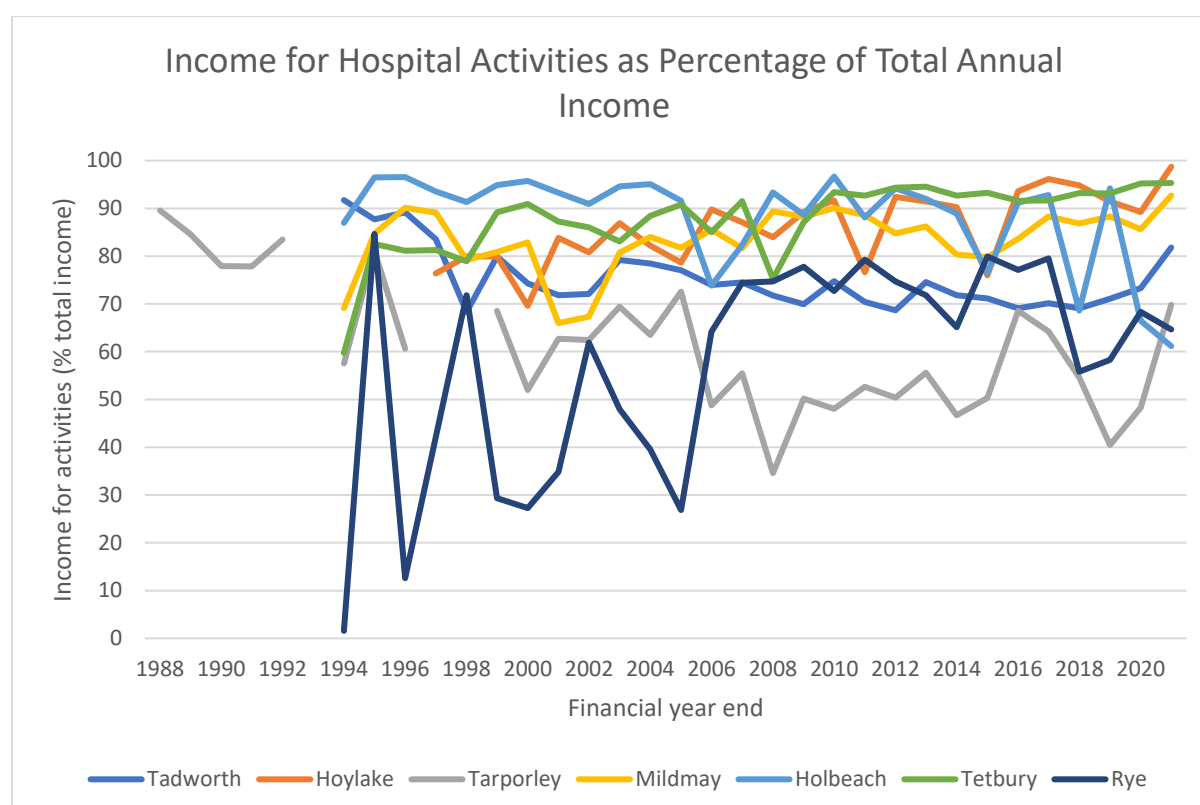


Figure 5: Income for hospital activities as percentage of total annual income.

Not every hospital reports on the sources of income for hospital activities. Tadworth and Hoylake, for instance, do not distinguish between different providers of income for hospital activities. This information is available through the Charity Commission, however the Commission only publicises records for the past five financial years at a time. Changes in the reporting practices of Holbeach and Tetbury also mean that the breakdown between funding sources for hospital activities is provided for some years but not others. Notwithstanding these limitations, by combining insights across Companies House, the Charity Commission, and qualitative data, we identified two broad sources of income for these hospitals’ charitable activities: public funding in the form of grants and commissioning services; and private funding in the form of patient fees and contributions.

Public funding

Since their transfer to charitable ownership, all nine hospitals continue to receive public funding in the form of payment for providing services to the NHS (i.e. contracts for treating NHS patients) and (to a lesser extent) grants. There is clear variation both between hospitals and over time in terms of public funding. Tadworth received the most public income over the past several years (Figure 6, 7), but public funding represents a larger portion of total annual income for Mildmay (Figure 8).

More on Paper than in Practice? The ‘Transformation’ from NHS to Charity Hospital

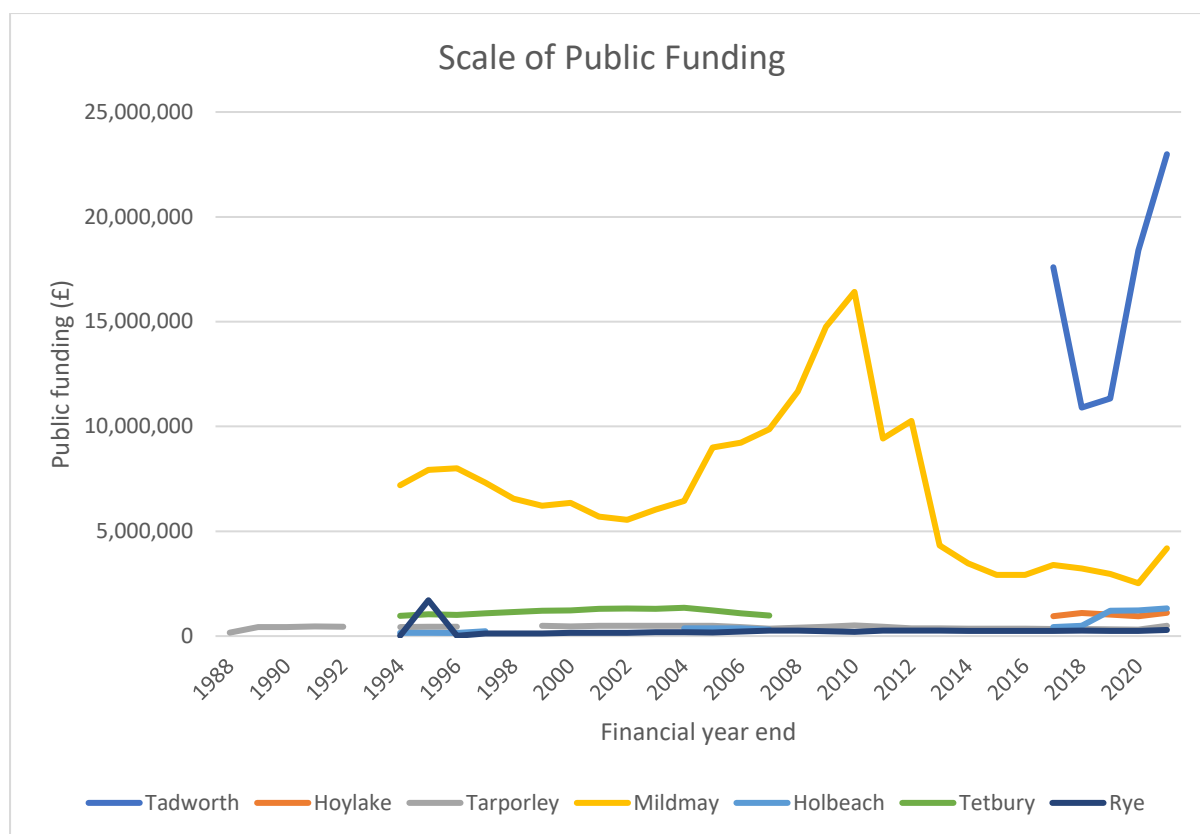


Figure 6: Scale of public funding for hospital activities.

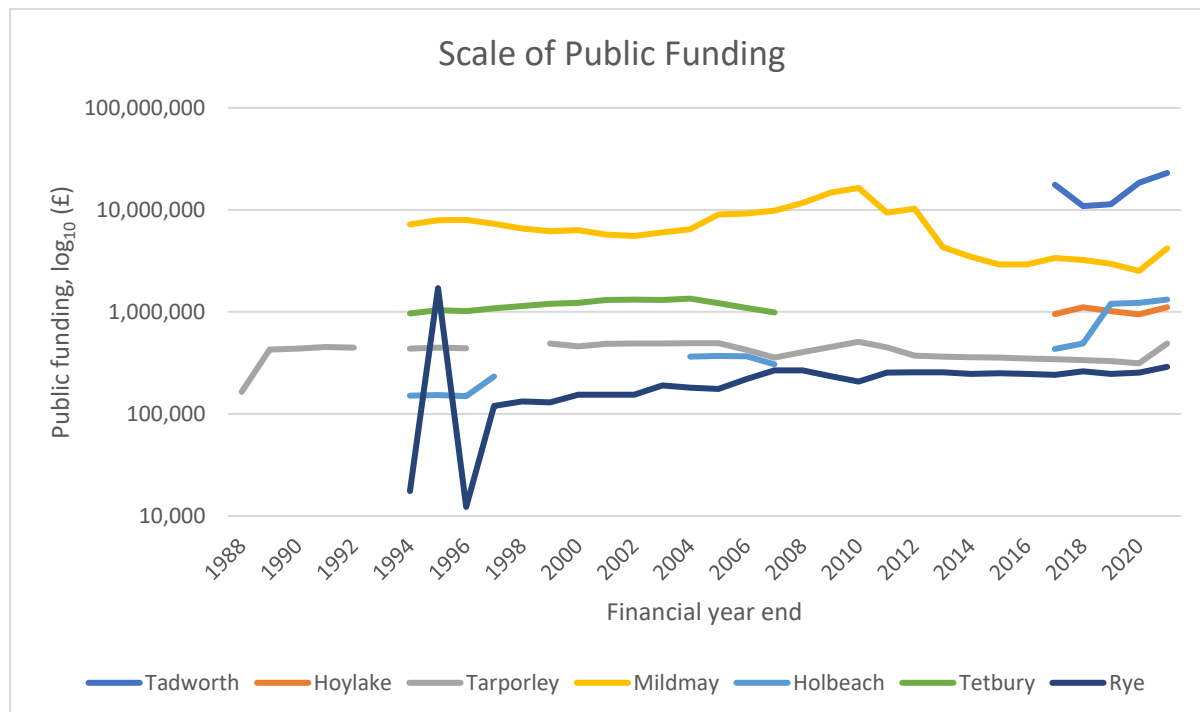


Figure 7: Scale of public funding (log scale).

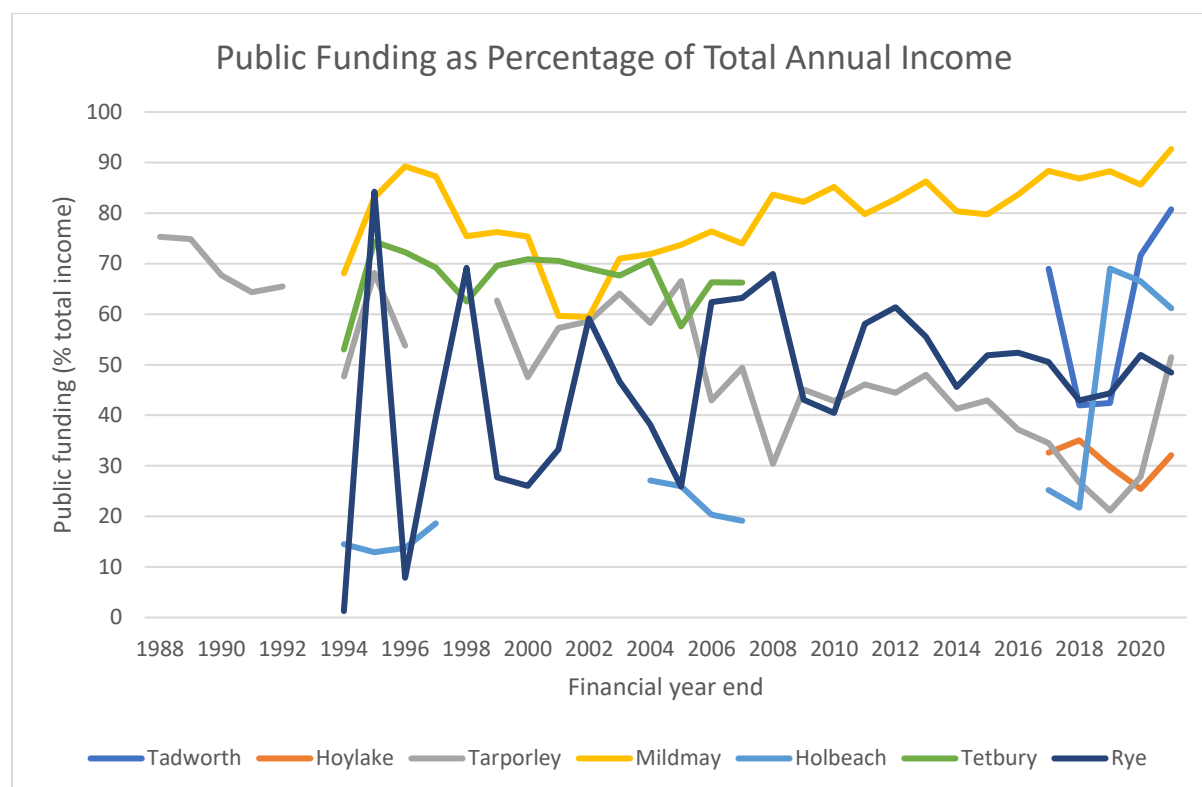


Figure 8: Public funding for activities/services as percentage of total annual income.

Several hospitals received public grants upon their initial transfer out of the NHS, intended to provide financial assistance whilst they established other income sources. For example, when Tadworth left the NHS, it received a government grant of over £2,500,000 in each of its first three years of independence. Similarly, the NHS provided a one-off grant of nearly £140,000 in 1987 to Tarporley upon its transfer (Tarporley War Memorial Hospital Trust, TWMHT, 2023). Most of the hospitals continue to receive public grant funding, in recent years primarily Government-provided COVID-19 relief grants.

The grants received by these hospitals are now dwarfed by payment for commissioned services. For instance, in 2021, Tarporley received £24,094 in government grants; it received £467,380 from contracts with the West Cheshire Clinical Commissioning Group (TWMHT, 2021). Across the hospitals’ online platforms and annual reports, commissioning contracts were portrayed as a more sustainable form of income than charitable donations and public funding for their services was portrayed as a responsibility of the state. As stated in an annual report for The Children’s Trust: “we do not wish to relieve the authorities of any of what we perceive to be their just and proper responsibilities” (Ball, 1998: 2). Mildmay notably receives public funding from both the UK government and from governments of developing nations (e.g. Uganda, Kenya) in which it also operates HIV/AIDS centres. As reported by the hospital in 2008: “Mildmay is dependent on global funds for much of its work – instability in the countries in which we work often means that monies are not reliable” (McLachlan, 2008). In 2019, Mildmay faced closure again – blamed on NHS funding constraints. A petition appealing for the Health Minister to intervene and directly commission Mildmay’s services received over 78,500 signatures. The petition closed in 2023, with campaigners declaring ‘victory’ as the Hospital would remain open following agreements to treat “a wider range of patients discharged from NHS Acute Centres across London who are part of a rehabilitation pathway” (Coleman, 2023).

Private funding

Only two hospitals – Tarporley and Tetbury – disclose the scale of private income received, and Tetbury stopped making this disclosure from 2008 onwards (Figure 9). In both cases, private funding has rarely exceeded 10% of total annual income (Figure 10). The small scale of both public (32% in 2021) and charitable (0.9% in 2021) funding for Hoylake implies the bulk of its income comes from private fees although this is not explicitly disclosed. Patient fees are not the only source of private income – Mildmay for instance receives fees for consultancy services, though the breakdown between private and public funding for consultancy is not provided in its financial statements.

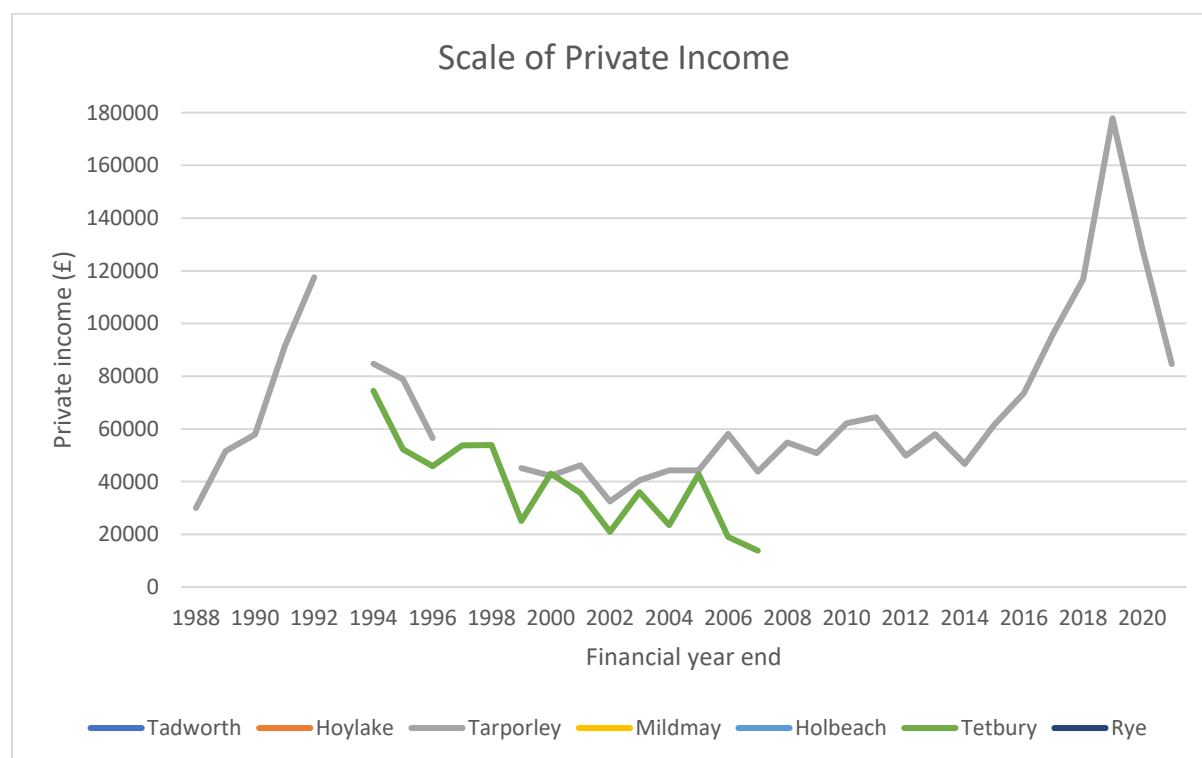


Figure 9: Scale of private income for hospital activities.

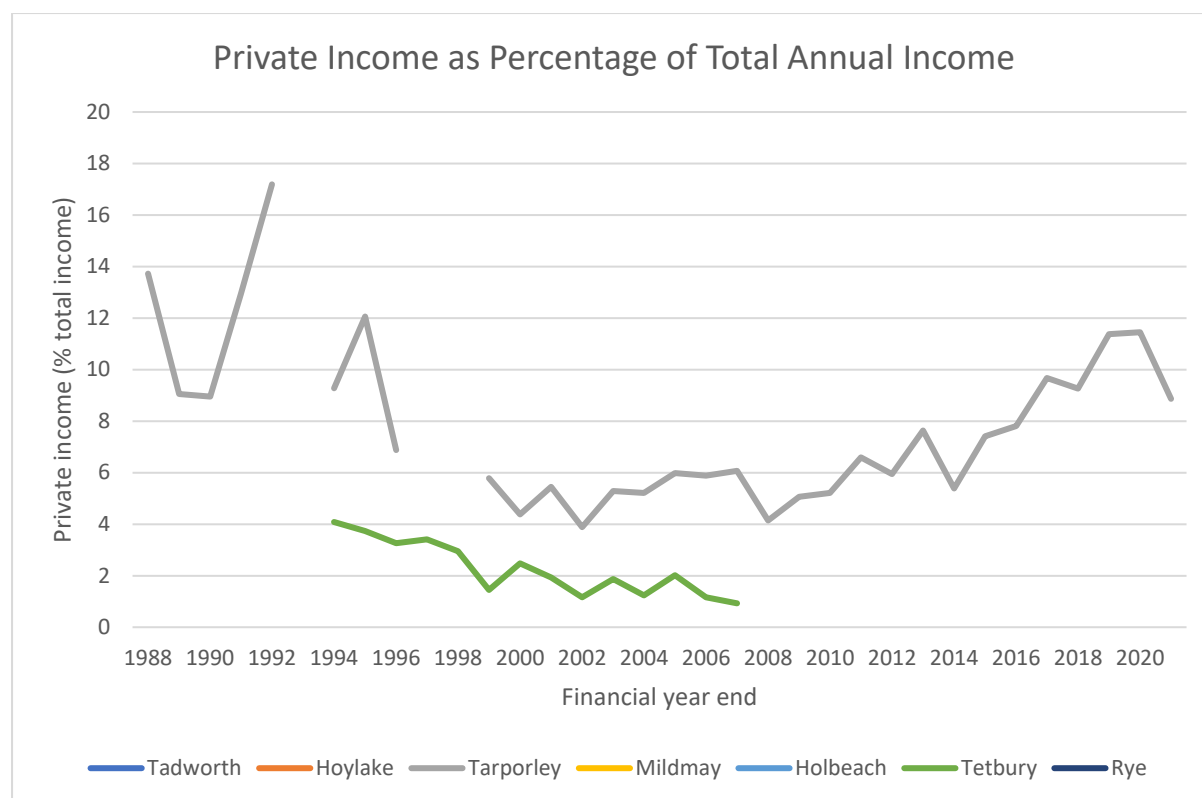


Figure 10: Private income as percentage of total annual income.

Uses of income for hospital activities

On financial statements, hospital (or ‘charitable’) activities conducted by the hospitals were broken down broadly into: care and rehabilitation services at the hospital; activities in and for the community; and other activities (Table 3).

Table 3: Uses of income for hospital activities.

Charitable Activity	Examples
Care and rehabilitation services at the hospital	▪ Nursing ▪ Day care ▪ Physiotherapy ▪ Outpatient clinics ▪ Day surgery ▪ Radiography ▪ Minor injuries
Community services (in the UK and internationally)	▪ Community services ▪ Training ▪ Consultancy ▪ Education (e.g. running school)
Other activities	▪ Catering ▪ Lettings/rental income ▪ Nursery

The profile of these services has changed considerably over time for most of the hospitals examined. Before leaving the NHS, eight of the nine hospitals were small general hospitals providing a mix of in- and out-patient services. The exception was Tadworth which has only treated children patients since its inception in 1929. Since their return to charitable control, the hospitals have taken different paths in terms of service provision including: (a) reduction of services, (b) expansion of services, (c) specialisation, and (d) closure.

(a) Service reduction: Tetbury, Hoylake, Holbeach, Odiham and Tarporley have all considerably reduced their services since transferring to charitable control. In several cases, this was agreed prior to their transfer to charitable control; in other cases, the service reduction came over time, following continued budget cuts and other pressures. Tetbury and Tarporley now provide only outpatient services as commissioned by their local health authority, whilst Hoylake and Holbeach have become nursing homes catering only for elderly persons in the community. In 2011, the NHS announced withdrawal of nursing services from Odiham – leading to the closure of all hospital beds. Again facing closure, the trustees of the hospital evaluated their assets (e.g. funding stream through charity shops, endowment fund, building, brand) and how these could be used to meet community needs, filling gaps in current service provision. Following a consultation with the community, they established a partnership model, commissioning services from other service providers – predominantly charitable groups but also NHS community services (Village Connect, 2021).

(b) Expansion: Rye has expanded the services provided on site since transferring to charitable ownership. Alongside the original hospital services – now provided out of a new building – the hospital also provides a care home, sanctuary housing, and a General Practitioner medical practice on site.

(c) Specialisation: Mildmay and Tadworth have both specialised since leaving the NHS. Tadworth – now The Children’s Trust – developed the UK’s first rehabilitation ‘hub’ for children with acquired brain injury. Across the charity’s website, annual reports, and other platforms and publications, the uniqueness of this service continues to be emphasised: “We are the UK’s leading charity for children with brain injury and neurodisability” (The Children’s Trust, TCT, 2023), and “the only organisation of its kind in the UK” (TCT, 2021). This specialisation is still clearly aligned with the hospital’s original mission to cater for sick children. Mildmay Mission Hospital is similarly presented across its platforms and records as pioneering and unique: after transferring to charitable ownership in 1985, Mildmay then redeveloped as “Europe’s first hospice caring for people with AIDS-related illnesses”, which opened in 1988 (Mildmay Mission Hospital, MMH, 2022a). This transition was somewhat contentious at the time: Mildmay was founded as, and remains, an evangelical Christian charity and, when it transitioned to a provider of care for those with HIV/AIDS-related illness, such conditions were particularly prevalent amongst gay men. This led to internal debates over whether caring for such patients aligned with their Christian ethos (Taylor-Thompson, 1992). Committee members concluded this path was consistent with the founding mission of the hospital: “The original brief of ‘heal the sick and preach the Gospel’ is as relevant today as it was at Mildmay’s inception” (MMH, 1988, p.2) Other suggested uses of the hospital facilities had been rejected by the health authorities during the 1982-85 campaign to keep the hospital open (Taylor-Thompson, 1992). The transfer of Mildmay to charitable control in 1985 was deemed the only way of continuing the Mildmay vision: “It would not be open to Mildmay to seek to recover the vision of its founders and apply it to the 1980’s with a freedom that would have been impossible if it remained within the NHS” (Taylor-Thompson, 1992).

(d) Closure: Brackley Hospital closed in 2015 due to issues recruiting staff. However, a new hospital – Brackley Community Hospital was opened in the NHS in 2020. This return to NHS ownership is described as “something which the town had long hoped for” (Brackley Community Hospital, BCH, 2023).

Charitable Income

The second largest source of income for the hospitals examined is charitable income, that is, solicited and unsolicited funds provided charitably from non-governmental sources, such as donations and gifts. All eight of the hospitals in our sample which remain in charitable ownership clearly promote the hospital’s charity status across their website and actively solicit donations and other charitable contributions.

The scale of Tadworth’s charitable income dwarfs that of the other hospitals we study (Figure 11, 12). This likely reflects Tadworth’s speciality – children with profound and complex health issues – which is amongst the more publicly popular causes to support in the UK (YouGov, 2022). Despite this, charitable income has rarely exceeded a third of total annual income for Tadworth and most other hospitals examined (Figure 13).

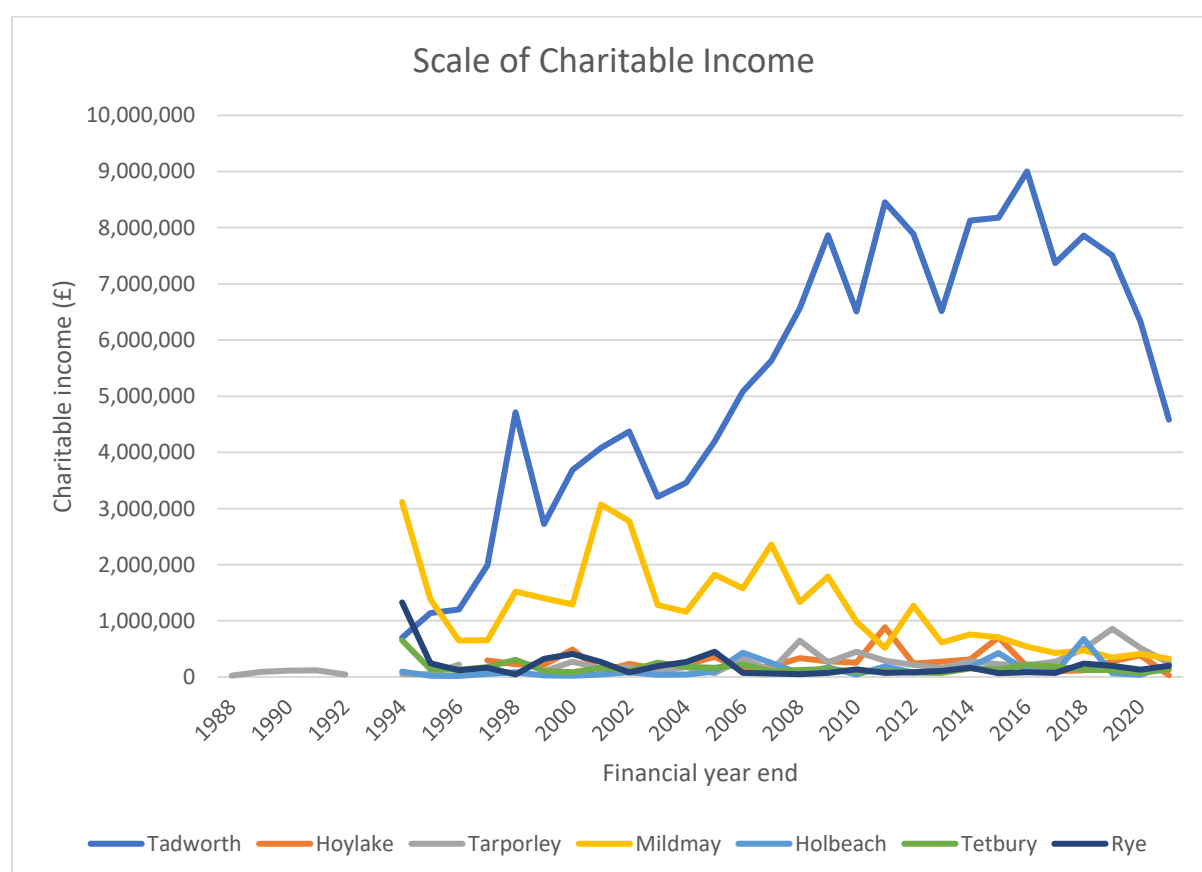


Figure 11: Scale of charitable income.

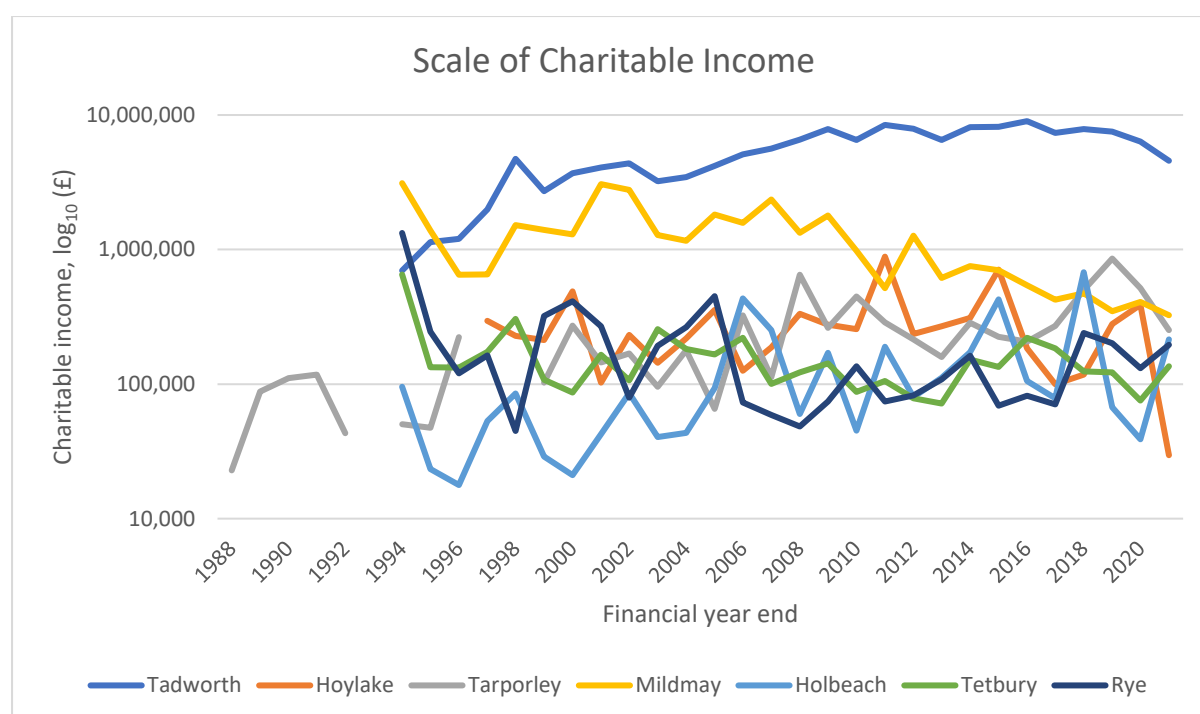


Figure 12: Scale of charitable income (log scale).

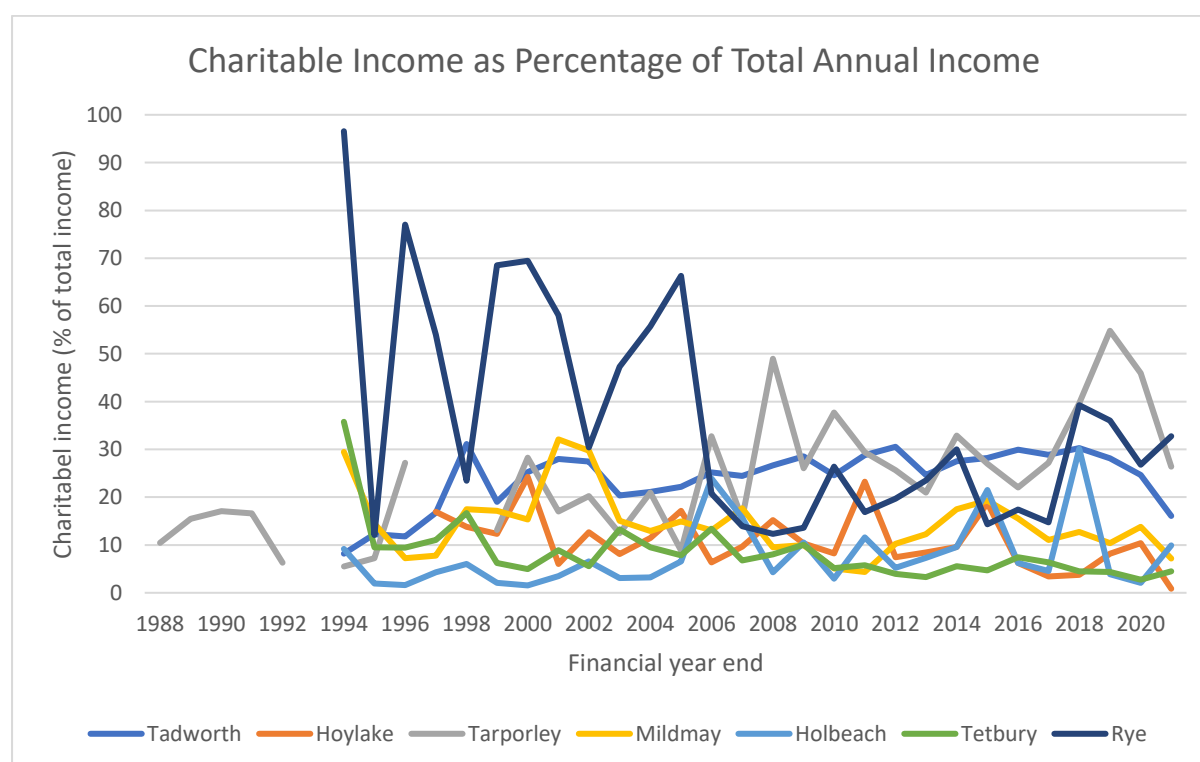


Figure 13: Charitable income as percentage of total annual income.

The scale of charitable income has fluctuated greatly over time for each of these hospitals. This fluctuation has been driven by variations in particular charitable income sources. Charitable income sources can largely be split into two categories, reflected in how they are reported on the hospitals’ accounts: ‘voluntary income’ – charitable contributions received such as

donations, legacies, grants; and ‘activities for generating funds’ – activities and events run by the hospital to acquire charitable income (Table 4). The fluctuations in the scale of charitable income per year are driven mainly by variations in: (a) legacy gifts – in some years hospitals received none or very small amounts, in other years they exceeded £100,000; and (b) fundraising campaigns – charitable income increased significantly in years when the hospital(s) ran a specific fundraising campaign or appeal connected to hospital development(s).

Table 4: Sources of charitable income identified.

Type of Charitable Income	Example Sources
Voluntary income	▪ Donations (regular giving, payroll giving, one-off donations, newspaper/magazine collections, contributions from community organisations) ▪ Legacies ▪ In memory gifts ▪ Sponsorship ▪ Amazon Smile ▪ Gift aid/tax recovery ▪ Covenants ▪ Grants (from foundations and corporations) ▪ Contributions from/subscriptions to League of Friends ▪ Gifts in kind (including gifts of freehold property) ▪ Sale of gifts in kind (e.g. sale of donated furniture)
Activities for generating funds	▪ Fundraising events (Summer and Christmas fairs, quiz nights, open days, fashion shows, charity polo matches, flag days, raffles/draws) ▪ Charity shop sales ▪ Lottery ▪ Café income

Uses of charitable income

Across the hospitals examined, charitable income continues to mainly be used for patient amenities, new equipment, and capital projects. Across the materials analysed, these hospitals portrayed their ability to provide high-quality, new, and in some cases innovative, facilities and equipment as stemming directly from their charitable status and funding.

For example, across its website and annual reports, The Children’s Trust at Tadworth is presented as “pioneering”, “leading the way”, and “state-of-the-art” (TCT, 2022). It runs an “Innovation Programme” and is currently building a £15 million new school site, of which most of the building costs will be funded through charitable contributions (TCT, 2021). The expansion and development of the Rye Hospital site has also primarily been funded by charitable income (Rye, Winchelsea & District Memorial Hospital, RWDMH, 2022a).

As well as building works and development, charitable income has also been used to fund new equipment. For instance, Mildmay Mission Hospital has a dedicated “Hospital Equipment Fund” to provide equipment ranging from televisions and fridges for patient rooms to rehabilitation and medical equipment (MMH, 2022b). Similarly, at Rye a recent fundraising campaign raised £40,000 for a new echocardiogram machine (RWDMH, 2022b). At Tetbury it is explicitly stated on its website that NHS funding is not given for capital projects or

equipment, so this is where charitable funds are used (Friends of Tetbury Hospital, 2022). Equipment for an eyecare clinic and newly refurbished X-ray room were provided by Tetbury’s League of Friends (ibid.).

This use of charitable funds is highly reminiscent of how charitable funds were utilised whilst each of the hospitals were a part of the NHS. For example, the League of Friends of the Odiham Cottage Hospital was established in 1955 “for the health, welfare and comfort of the patients therein, by the provision of facilities, buildings and equipment which may be required for the treatment of such patients, or, for the efficient running of the Hospitals” (Reggler, 1999: 43). The League paid for various provisions ranging from medical equipment to radios, and from insurance premiums (on equipment) to Christmas parties and decorations. Since its transfer to charitable ownership, the League continues to support the hospital in much the same way, funding equipment, capital projects, and staff and patient amenities.

Notably, these hospitals’ current use of charitable funds is also similar to the case of Brackley which re-joined the NHS in 2020. Upon the reopening of the hospital in the NHS, the Brackley Hospital Trust (which had owned and operated the hospital outside of the NHS) was closed and a new trust – the 2020 Brackley Community Hospital Trust – was established. This new Trust fundraises “for equipment not funded by the National Health” (BCH, 2022) such as: an x-ray machine, an ultrasound scanner, televisions for patient rooms, and chairs for patient and visitor use.

Only two of the hospitals (Tarporley and Odiham) explicitly use(d) charitable income to subsidise the cost of services. A leaflet distributed soon after the transfer of Tarporley Hospital explained that whilst most services would still be paid by the health authority, “patients whose bill is not to be paid by the DHSS or a private medical scheme will have their bill paid for by the League of Friends” (Tarporley War Memorial Hospital League of Friends, c.1987). From its transfer in 1998, the cost of nursing care at Odiham Cottage Hospital was reportedly subsidised by charitable donations, “making it a very attractive proposition financially for the NHS”. Odiham residents reportedly raise c.£90,000 per year (Village Connect, 2021).

Investment Income

The third funding source identified for the nine hospitals examined was investment income (Figure 14, 15). For most of these hospitals, investment income is a relatively small income source, consistently accounting for under 10% of total annual income (Figure 16). In 2021, investment income represented less than 5% total income for all seven hospitals for which financial data was available. The occasional peaks in investment income are driven primarily by sporadic increases in bank interest received.

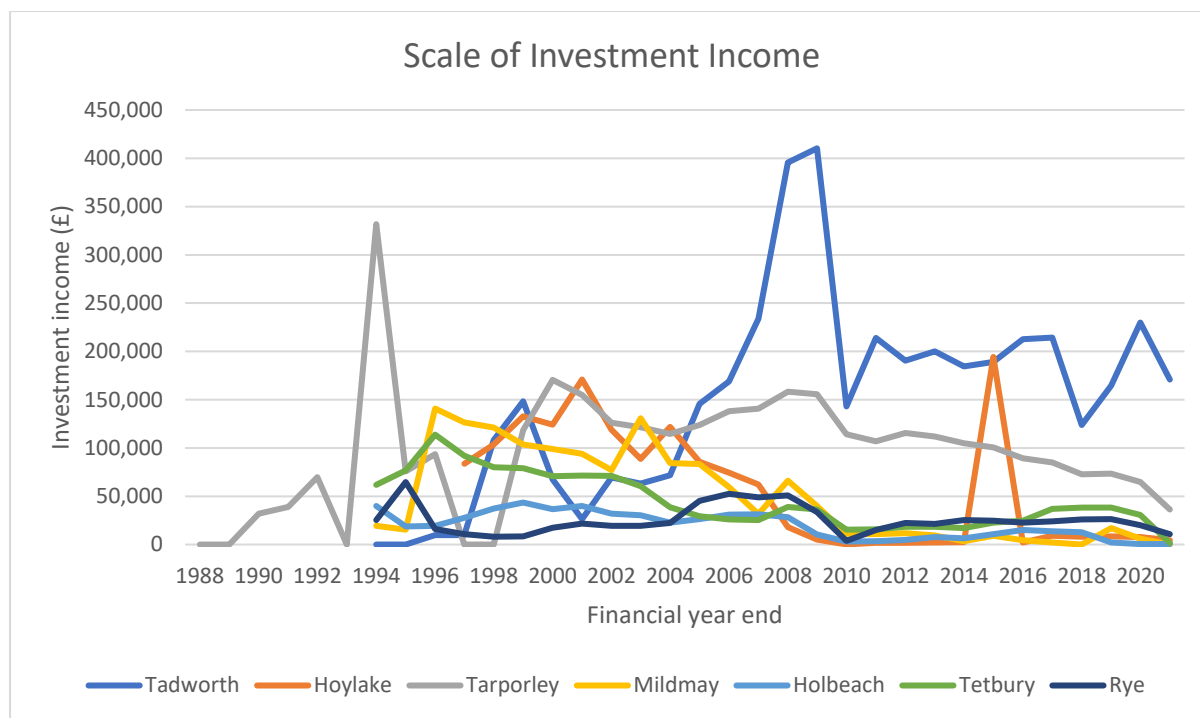


Figure 14: Scale of investment income.

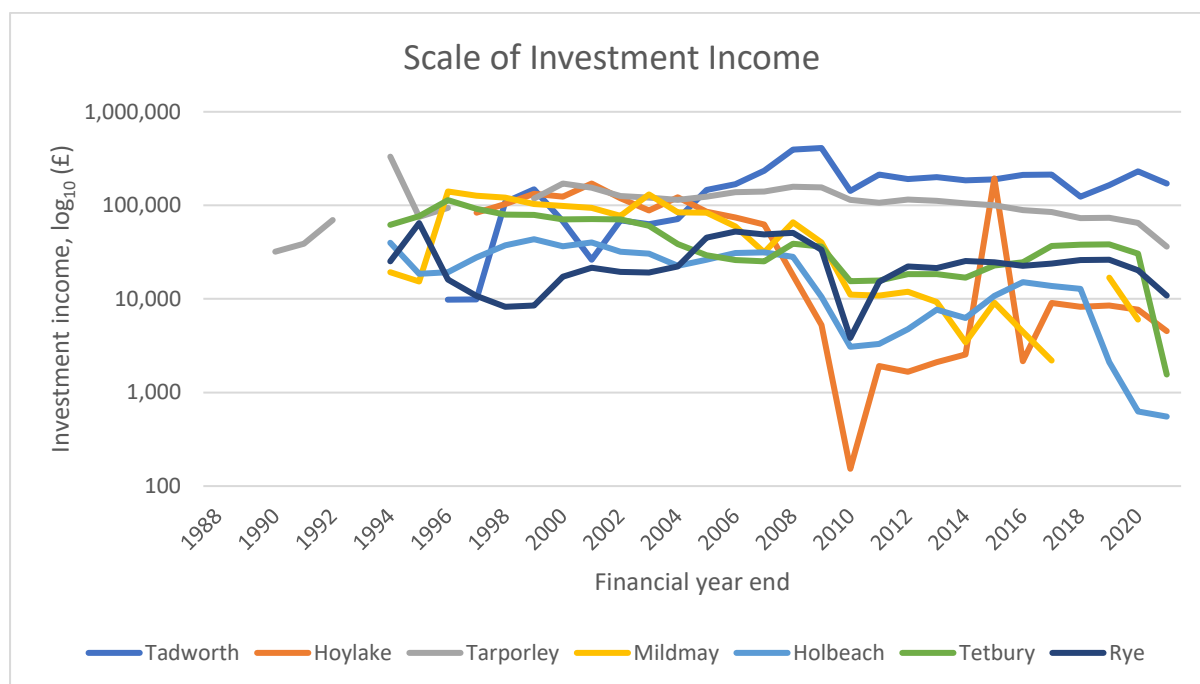


Figure 15: Scale of investment income (log scale).

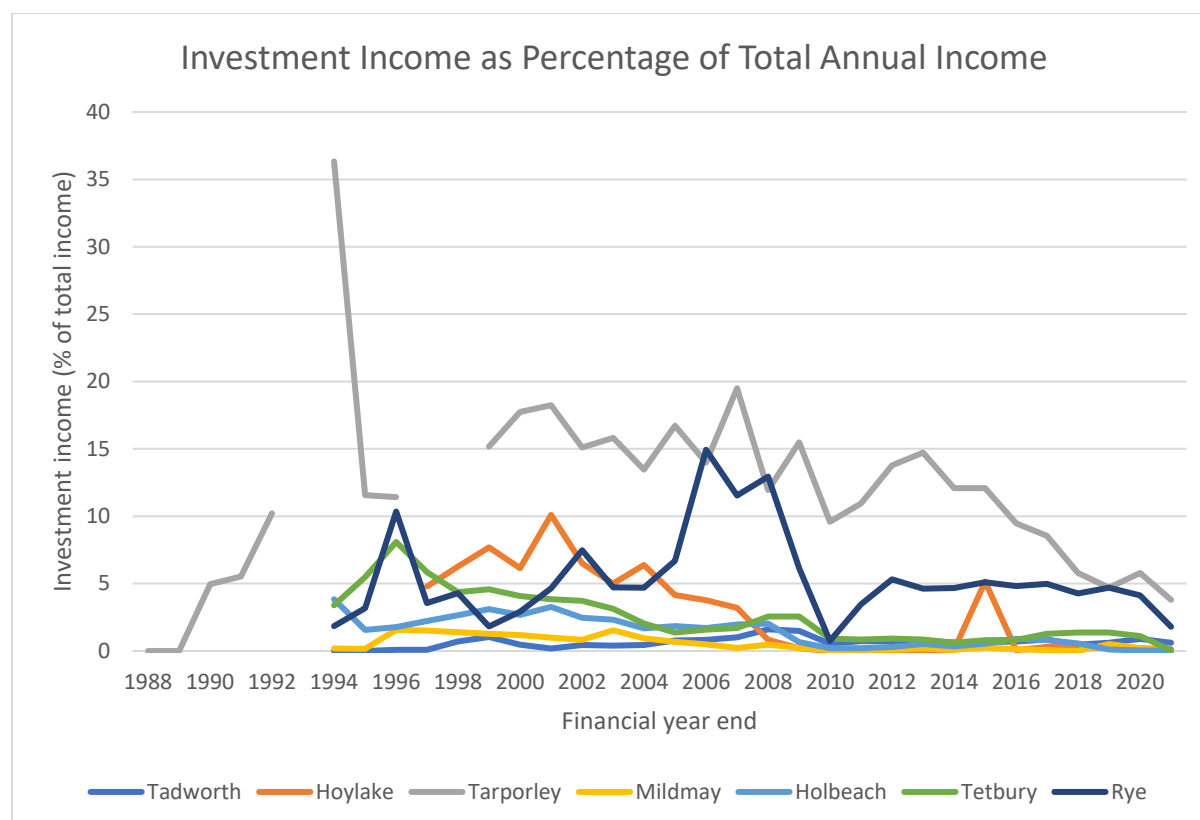


Figure 16: Investment income as percentage of total annual income.

We identified several sources of investment income for these hospitals: dividends (on UK and overseas investments); bank interest; unrealised gains on investments; and profit on sale of investments. In several cases, the funds invested came from public contributions which were placed into endowment funds.

Qualitative insights from annual reports reveal investment funds are primarily used to build reserves, hedging against economic uncertainty. For example, Odiham reports a ‘cautious’ approach to managing their investments: “Whilst investment returns form an important part of our charitable income, the Trustees have been careful to protect the underlying value of OCHCT’s capital which has recovered much of the previous year losses due to impact of COVID-19 on the financial markets.” (Deverill, 2022: 4).

Other Income

In addition to the clearly defined categories above, all seven hospitals also include a category on their financial statements for ‘other’ income sources. These were largely unspecified sources of income, but also included some specified sources such as compensation and insurance claims. This income is generally very small (Figure 17, 18); in 2021, other income represented less than 1% of total annual income for six of the seven hospitals for which financial data was available (Figure 19). Mildmay had a notable peak in ‘other’ income between 2010 and 2012: the source of this is unspecified in the hospital’s financial statements and reports. Given their

More on Paper than in Practice? The 'Transformation' from NHS to Charity Hospital

small scale and unspecified origins, the uses of these income sources were also not provided in any of the materials examined for any of the cases.

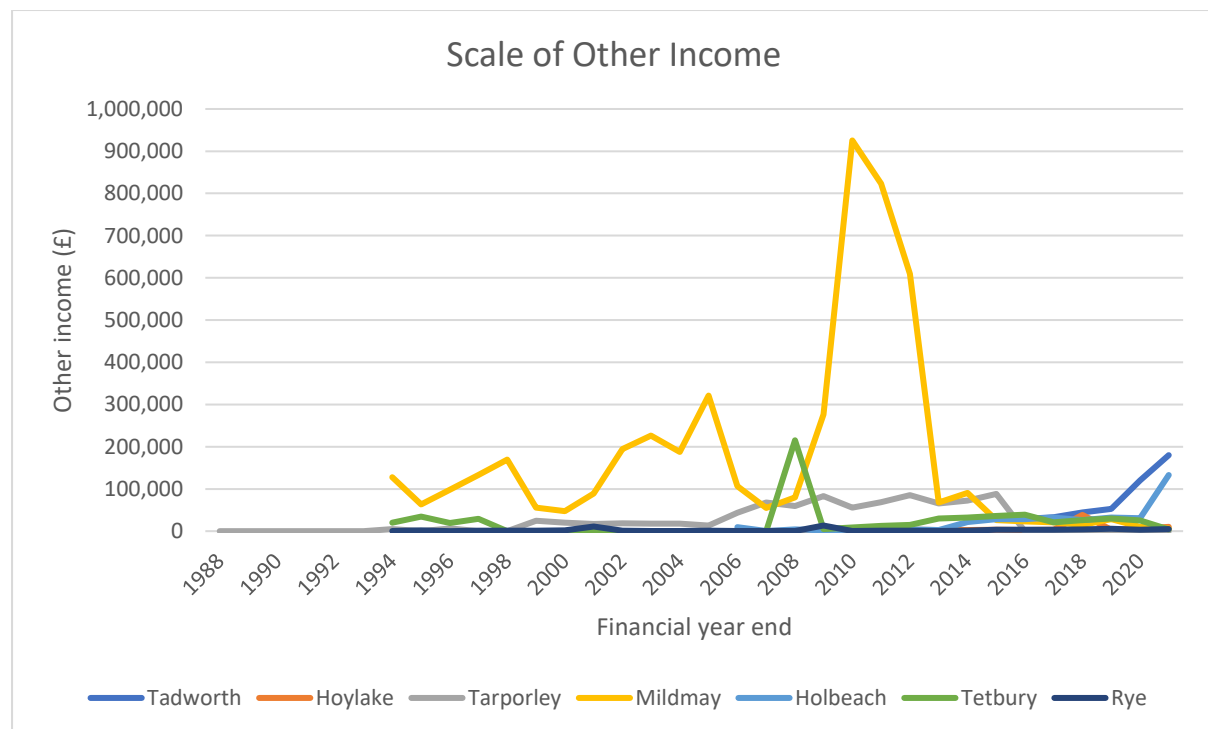


Figure 17: Scale of 'other' income.

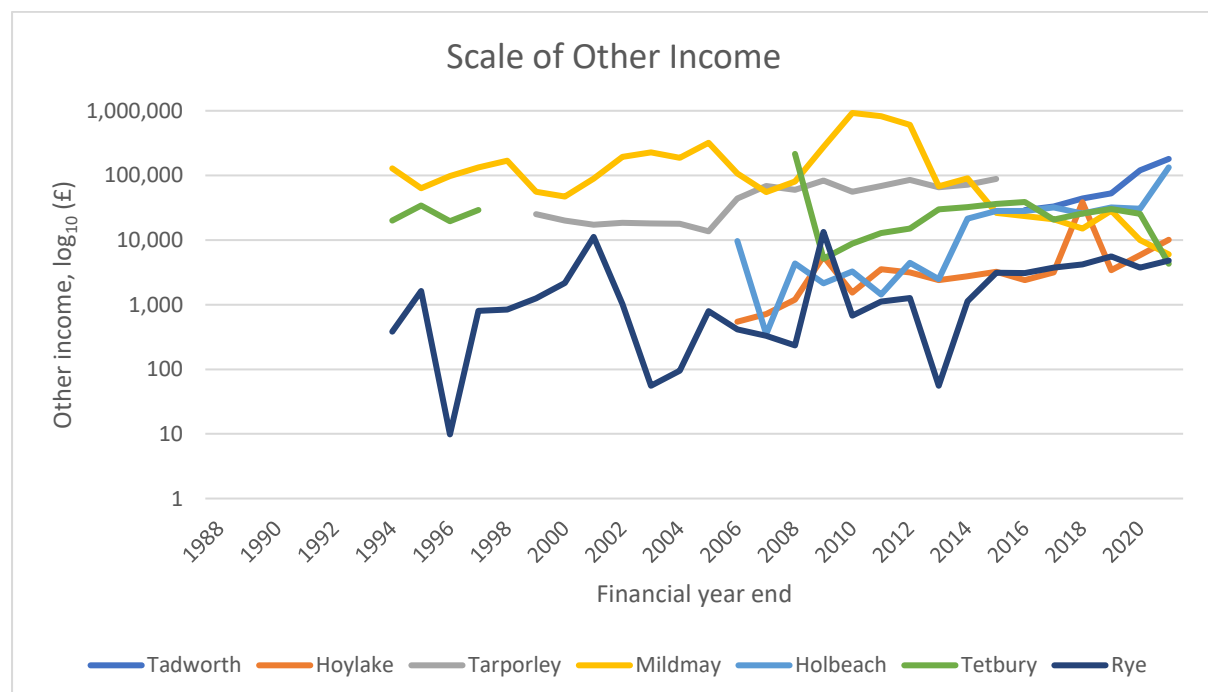


Figure 18: Scale of other income (log scale).

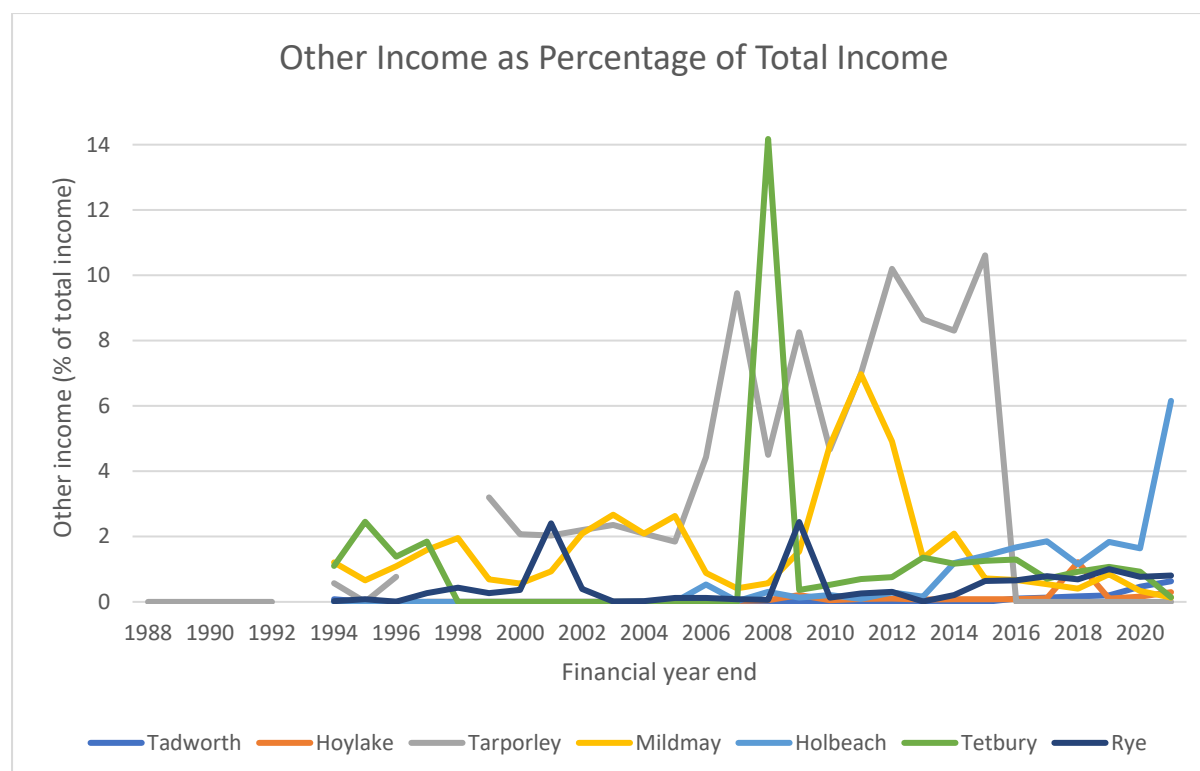


Figure 19: 'Other' income as percentage of total annual income.

Discussion

At the time these hospitals transferred to charitable control, there were two main arguments made by proponents of the institutional move: (1) to access non-public resources (e.g. private, charitable), decreasing the fiscal strain on government resources; and (2) to enable these organisations to innovate outwith the bureaucratic confines of state ownership. Below, we critique these claims and examine whether they have been achieved in practice.

First, transferring hospital control to voluntary bodies was portrayed as an opportunity for reducing government expenditure as services could be funded or subsidised by non-public resources. Voluntary organisations were also deemed cheaper service providers than public organisations as their costs are subsidised by donations and some roles are provided by volunteers (Yeo, 1985). Analysing 30 years of financial reports for the hospitals in our sample reveals they continue to predominantly be funded by the NHS through contracts. The limited data regarding private contributions show this is relatively small, with the exception of Hoylake which appears to have become a private nursing home dependent mostly on private patient fees. Charitable contributions are substantial in some cases, though they are dwarfed by public contracts and are predominantly used to fund 'extras'. This can be argued as a public saving as donations are being used to fund expansions and equipment rather than the public purse. However, it is no different to when these hospitals were in the NHS (and is the case for Brackley now back in the NHS). Only two cases describe using charitable contributions to directly subsidise the costs of services and the value of these is unknown.

Second, voluntary bodies were considered more able to innovate and take risks than public organisations which are slowed and restricted by bureaucracy. Given the continued reliance of these nine hospitals on government funding, (how) has this shaped their development and ability to innovate? Over-dependence on government funding can reduce an NPO’s ability to adapt to social needs (Anheier et al., 1997; Verschuere & De Corte, 2014; Doyle et al., 2016). Investigating the paths taken since their transfer to voluntary control reveals mixed insights in this regard. The experiences and development of Tadworth, and Rye concur with proponents of the resource dependence strategy: their dependence largely on government funding to provide services provided financial stability needed for growth over time (Carroll and Stater, 2008; de los Mozos et al., 2016; Shon et al., 2018), without compromising the mission of the hospital and its ability to adapt to meet community needs (Doyle et al., 2016). Both organisations have evolved considerably over time, and changed and increased the services they provide according to community needs. In both cases, their development has continued to align with their founding mission. In contrast, the experiences and development of most other hospitals examined highlights that over-dependence on government funding can increase financial risks, leaving them vulnerable to funding cuts and potential closure (Barrett & Holliday, 2018; Kearns, 2007). For example, with the funding and support of government, Mildmay evolved into an innovative healthcare facility following its transfer – despite its considerable change from an acute hospital to an HIV/AIDS hospice, members of the hospital maintain this remains aligned with the hospital’s evangelical Christian mission. However, Mildmay’s continued reliance on UK and foreign government funds, left it exposed to changes and volatility in government policies. Mildmay faced closure again in 2019 following further NHS cuts, being saved only following negotiations with health authorities and agreement for Mildmay to widen the services provided beyond its specialist care. Odiham similarly faced closure again in 2011 after the NHS withdrew funding. The charitable ownership and status of the hospital was praised as the key reason for the hospital remaining open – enabling hospital trustees to identify gaps in community services that they could meet with their asset base.

These differing experiences post-transfer highlight the contextualised nature of each case, the ability of different communities to raise funds for their hospital, and the attitudes of local health authorities towards commissioning services from independent healthcare providers. Whether a given hospital expanded, reduced, or specialised its services seems to have largely aligned with the needs identified by their respective health authority and the services they were willing to pay for.

It is notable that in all nine cases, the hospital was set to close under the NHS before transferring to charitable ownership. When facing closure in the 1980s and 1990s, these organisations stayed open instead of closing because of charitable initiative. Today, their ability to raise charitable funds has most affected their ability to grow physically – charitable funds are nearly solely used to provide equipment and fund capital projects. Their continued survival has instead been ensured by their large dependence on government funding. As summarised by Lattimer (1994), “Put crudely, charity led the way, but it was left to the NHS to foot most of the bill.” This mirrors pre-NHS hospital provision: these hospitals are not necessarily any more needed than others, but their survival (just as their initial birth) stemmed from the ability of the community to provide charitable resources (Abel-Smith, 1964; Gorsky et al., 1999). Whether this is evidence of the insufficiency of charitable funds (Salamon, 1987), the crowding out effect (Rooney, 2007), or of the continued perception (amongst hospital fundraisers and their supporters) that hospital activities and services are primarily the responsibility of the state, it raises concerns because it is only accessible to those communities who have (access to) sufficient capital to take on the ownership and control of the hospital (Lattimer, 1994).

Conclusions

This paper has examined the nine hospitals in England which, during the 1980s and 1990s, transferred out of the NHS and into charitable control. On the surface, this appears a return to their pre-NHS (i.e. pre-1948) status of voluntary hospitals in which they were primarily reliant on voluntary contributions, including legacies, donations, and subscriptions. In reality, these hospitals’ current means of resource acquisition and use are more similar to their NHS era – most are predominantly funded by public monies through contracts and (to a lesser extent) grants, with charitable funds being used predominantly for ‘extras’ such as patient amenities, equipment not funded by the NHS, and building refurbishment and extensions – just as they were when these hospitals were a part of the NHS. The organisational change from NHS to charity hospital therefore appears to have taken place more on paper than in practice.

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