CHAPTER II

SOCIAL HISTORY OF ‘NOT-FOR-PROFIT’ HOSPITALS
Social History of ‘Not-for-profit’ Hospitals

“\textit{It might be safe to assert that history is at least additive and cumulative....And in this sense the history of the hospital is of consequential importance for understanding some of the contemporary complexities of the present social organisation of the hospital....}” (Rosengren, W. R., 1980)

Introduction

This chapter traces the evolution and social history of hospitals in Europe and North America, from the medieval age, through the renaissance and the rise of capitalism that provided the basis for the growth of scientific knowledge. The emergence of hospitals and their role has been shaped by a number of factors. These include the socio-economic context, the relation between charity and medicine, the growing urban centres and the emerging classes, promoters of the voluntary hospitals, the motivations behind setting up such institutions, growth of science, the understanding of causation of diseases, the role of medical professional and their practice, and state interventions in medical care and growth of markets.

Diseases preceded humans and medicine and surgery began at the beginning of civilisation. Priests were the medicine men, ministering to the body and soul and they were also part of the ruling class. Medicine is said to have first appeared 4000 years ago in Mesopotamia, south-west Asia and the first recorded doctors were present in Babylon from 1728-1686 BC. Medicine was largely a private affair in earlier times but the presence of institutions has been recorded since time immemorial. It is noted by historians that Christian hospitals were no match for the number, organisation and excellence of the Arabic hospitals. Asylums were founded 10 centuries before Europe in the Arab world. All major religions of the world had some form of medical institutions for their communities.

Hippocrates personified a non-religious, rational approach to medicine and performed surgeries. The understanding of causation of illness and disease by the medical profession was inherited from traditional Greek medical system that was essentially secular i.e. the causation of disease was seen to be the effect of natural factors. The humoral theory of disease was the basic framework used by the medical profession for conceptualising the body, subscribed by Hippocrates (460-370 BC) and remained a dominant approach for
centuries. Under this, the world was conceived of four basic elements (fire, earth, air and water), four qualities (hot, cold, dry and wet), four humors (blood, phlegm, yellow bile and black bile) and four personality types (sanguine, phlegmatic, choleric and melancholic). Therapy consisted in attempts to restore balance between the humors and this was attained through diet, rest, blood letting and some form of alchemy (Turner, 1995).

**History of Hospitals in Europe**

According to Turner (1995), the history of hospitals in Europe can be divided into three phases. Religious foundations from 335 AD to 1550 AD provided the basis for most hospitals in the early history of European societies. The period of religious foundations began with the order of Constantine who adopted the Christian faith and closed temples to erect Christian hospitals. This ended with the collapse of many monastic hospitals in the 16th century during the period of Reformation. According to Rosen, several hospitals were also funded by merchant guilds and funds were provided for medical care and social assistance of their sick and disabled members. Wealthy guilds built their own hospitals. By the middle of 14th century, there were more than 600 institutions founded by guilds ranging in size from numerous small foundations to larger establishments (cited by Baru, 1998). The second period of hospital development that occurred in 17th century was for different reasons and by a different class of people. These hospitals were established by the middle class philanthropy and rich merchants and were based on the utilitarian principles in a laissez-faire environment. The new hospitals were typically not supported by the Church, the state or tax payers, but maintained their independence through the benefactions and donations by individuals (Turner, 1995). Large hospitals emerged in the late 19th and early 20th century as a result of growth in technology, professionalisation of medicine and the entry of the middle class in to hospitals.

While Christian hospitals dominated the European scene, an important contribution to emergence of voluntary hospitals in Europe was by the Jewish who were the minority community. They had their guilds present across Europe and made donations to the set up of voluntary hospitals. Many a times the Jews were not allowed in to Christian voluntary hospitals.
Table 2.1 - Historical evolution of hospitals in Europe

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The Medieval Era and Period of Renaissance

In medieval Europe the Church bore the responsibility for organising and promoting poor relief. Institutions providing care were products of a feudal society where the Church played a dominant role in people’s lives and demands made by science were very little. The Church saw illness as a punishment by God or a form of instruction to the soul. The Church derived its reason from the seven deadly sins by Gregory the Great (540 – 604AD) of anger, envy, dejection, covetousness, vanity, gluttony and sloth (Turner, 1995). Hospitals were funded by the church and directed towards providing shelter to the sick poor, lepers and mentally ill and were looked at as places of impurity and death rather than of cure. The upper class sought respite from illness from the then lay practitioners, healers and alchemists.

Early hospitals were also rest houses or way-stations for people who fell ill during religious pilgrimages. These were of course completely unspecialised and operated as open houses for the sick, the old, the poor and the infirm. Most monasteries had hospitals attached to them. In addition there were also alms houses that were charitable housing for the poor and
elderly that could also function as hospitals. The earliest form of hospital specialisation was the development of the ‘spital’ for those suffering from leprosy. These were known as lazars. Other forms of specialisation were related to institutions for mentally-ill and lying-in hospital. Two big medieval hospitals in London provided obstetrics and provided charitable support for children whose mothers had died during childbirth. The medieval institutions depended a great deal on patronage and church support. Some hospitals also raised money through such mechanisms as charging admission fees and through taxes from local population.

Rubin’s (1991) study on medieval hospitals from 12th to 14th century in England finds very little about the type of ailments and medical care that was provided to the inmates but gathers that some hospitals were founded by leading ‘burgesses’. She says, “In the act of foundation a maturity of the collective urban enterprise was demonstrated, and yet within this cooperative endeavour some distinctly personal aims were being achieved: in personal rewards in the form of commemoration, through involvement in the management of the hospital’s property, in the facility of buying, selling and borrowing from a well-disposed institution, and finally through participation in acts laden with symbolic expressions of largesse, of authority, of virtue – of power” (Rubin, 1991). Another interesting observation that she notes during this period is the emergence of newer organisational forms of these charitable institutions. Organisational forms were adopted from secular religious sphere of life so as to minimise intrusion and to ensure its smooth functioning. So hospitals followed patterns of ‘secular collegiate houses’ that were religious institutions but functioned separately and independently. This was an important form of institution in this period and had evolved from the period were institutions were managed and run by the church endowments. Many hospitals therefore, in the 12th and 13th century attracted patronage and the symbolic act of giving was of vital importance. But mostly endowment was small and very few made large endowments. One also notes a decline of these institutions in the 14th century. There is evidence to show decline of endowments in some towns.

Few scholars argue that it is not clear whether charity was stimulated by economic slumps or booms. Some argue that charity changes with varying economic contexts. Therefore when there was a slump there was greater welfare activity and rise in immediate charity giving while during booms long-term institutional charity was prevalent (Cavallo, 1991; Rubin, 1991). Rubin argues, “Endowment can occur in an atmosphere which is, on the whole, favourable to collective action or in one which is not. The examination of the whole
variety of charitable choices within a town or a region, the inquiry whether the fall off in some is countered by the setting up of different types of institutions, can teach us about clusters of shifting understandings of charitable act.” The hospital was constructed within the changing language of charity in different social contexts.

**Development of modern science and medicine**

The changing language of science and medicine was also important. History of science shows that the social and economic advance has been essential precursors to the development of science. Growth of science is linked to growth of capitalism and demands of a changing economic order. Scientific activity occurred in the Greek period, Renaissance, Industrial revolution and in the present era of liberalisation and neo-liberalisation and it is important to see the interaction of science with society in these phases that influenced medical profession and growth of institutions. “Both the major and minor creative periods in science and technology appear in history as accessory to great social, economic and political movements” (Barnal, 1965). From the phases of capitalism that began with Renaissance, science has been given social importance and material means and is continually stimulated to new activities by problems that emerge from the economic and social spheres. These problems have essentially touched the interests of the ruling class and the honour and opportunity given to practitioners of science at any time are a measure of the degree to which they serve the interests. People who are occupied with science are closely in touch with the main economic interests, and are often drawn from the directing classes or brought in by them because of their abilities. These have been seen in times of Archimedes, Leonardo, Galileo, Pasteur etc. (Barnal, 1965).

The development of modern science is the key event of 17th century. This started with the period of Renaissance i.e. the 15th and 16th century that represented a rebirth in the arts, philosophy and scientific endeavour, technological advancement and medicine to some extent. Science, during and after renaissance had little impact on medical practice but this period saw the beginnings of new developments. From the point of view of science, perhaps this was the most important period that marked the beginnings of a changing feudal economy to a new bourgeois economy. This was the beginnings of a laissez-faire and capitalist economy. The credibility of the church and many of its dogmas were questioned as new scientific discoveries were made. The growth of science was a general struggle against orthodoxy and superstitions. In fact, the Renaissance opened the door to individual thinking and the Reformation was an outcome of this new emphasis on individualism. Astrology and
Alchemy that were reputable sciences in their time were taken over by astronomy and chemistry. The astronomical core was the centre of Greek science and philosophy and was extended to explanations of human physiology. Diseases were described and there was good diagnosis and prognosis but treatment was to let the patient alone. On the other hand, in the other parts of the world, for example, the Chinese and the Arabs were breaking away from the limited Greek science to chemistry and optics.

It was only in the late 17th century-early 18th century that interest in science shifted from astronomy to mechanics. Medicine was integrally involved with the development of mechanistic science. The understanding of the body was merely as the homologue of machine (Barnal, 1965). Descartes, Harvey, Bacon were the proponents of this viewpoint. One doctor whose medical views derived from this mechanistic framework was George Cheyne (1671-1743). He believed that health of this system of pipes and pumps could be maintained by regular supply of food and liquid. The employment of surgery and drugs were secondary to the dietary management. Cheyne’s dietetic management was part of a wider religio-moral tradition in which the management of the body was a religious calling and he combined these moral and medical views (Turner, 1995). Within this mechanistic understanding of the body, diagnosis was a more important medical task than treatment.

Medical practice and hospitals during Renaissance

Medical practice was virtually still outside the hospital and hospital appointments were not sought after by the profession. "The organisation of medical care reflected very clearly the class divisions in society" (Doyal, 1979). The three types of practitioners that were present in the order of hierarchy were: the physician who was a professional and his practice was limited to a small and wealthy clientele and they preferred to work through regimen or diet, sleep and exercise; the surgeon was a craftsman and limited to a small range of surgical procedures like bloodletting by the use of leeches, set fractures, sutured wounds in the absence of anaesthesia or antisepsis and their status was lower than the physician; the apothecary was a tradesman trained by apprenticeship and dispensed drugs but by the end of 17th century many were diagnosing and writing prescriptions (McKeown, 1971). The home was seen as the safest place to receive treatment. The physician was most respected with his university degree who himself came from the upper class. The surgeon was trained by apprenticeship and was limited to carry out surgical work. Their position started to rise only after the voluntary hospitals came up later. Drugs were limited to mercury, iron, quinine, and digitalis (Tuckett, 1976). The medical profession was not organised and medicine was
available to a minority of population. Hospitals around 16th century had not gained much importance and the purpose of institutionalisation was limited to the segregation of the infectious, insane and to house the destitute.

Park, K. (1991), describes the hospitals in Florence during renaissance in the later fourteenth and fifteenth centuries. Around thirty-five hospitals were active at that time. Most of these were general charitable institutions established and supported by private citizens, guilds offering short or long term shelter and maintenance to the needy and were not organised to provide medical care. But there were few public hospitals that provided care to the sick poor.

In England many hospitals disappeared during reformation when monastic hospitals were closed in order to raise additional revenues for the monarchy but by the 17th century the charity hospitals came up that were now a product of philanthropy rather than religious zeal and the motivations were more utilitarian than simply Christian charity (Turner, 1995). All hospitals that existed were voluntary and charitable and funded largely by middle-class philanthropy. These new hospitals were patronised by a new class of rentiers rather than by rich merchants. They were typically maintained through the benefactions of individuals and were often served by unpaid medical staff. There were individuals linked directly to the church and they were also financed by endowments, voluntary subscriptions by leading local magnates who were also presidents of these institutions. Other than the religious obligation, it has been noted quite often that involvement in establishing such charitable institutions was partly out of concern for individual's own position in power or status. Cavallo shows in her study on England that charity was often a ground for power struggles between rival elite groups. She states that participation in the management of hospitals and other structures of poor relief favoured the creation of networks of interests, business links and influence over work and career opportunities. These studies have started to root charitable action in a specific political scenario, for example, to see it in relation to the opposition between urban elites and landowners, or to rivalry between different factions of urban elite or a need to create common objectives and integrative mechanisms after a period of division and conflict (Cavallo, S., 1991). For example, local and central government or various political parties may support different charities. As the number of charitable institutions expanded in Britain in the eighteenth century so did special fund-raising events, anniversary celebrations and meetings. During the mid-eighteenth century, benevolent societies would court middle and upper class people with invitations to such events. These people could choose from various
hospitals, dispensaries, lying-in charities and efforts to reform poor for public benefit. Central to all such proceedings was ‘display’ (Loyd, 2002). The hospitals were primarily concerned to provide shelter for the homeless, sick, orphans and unemployed and were typically poor ventilated, cold, unclean and overcrowded. Mortality rates were high in these institutions and were places where middle class did not seek cure or rest.

It was not until the 16th century that the state began to take over some responsibility of intervening in some way in providing medical relief in some parts of Europe. For example, renaissance Italy shows Italian communes subsidising hospital provision. In 18th century France, Napoleon II offered indirect support to mutual aid societies but these instances of state intervention were very few (Barry and Jones, 1991). In England, the institutions that came up as a result of state intervention around this time were seen as agencies of confinement, social control and repression rather than care and cure. The institutional forms that came up with the Elizabethan Poor Law Act of 1601 were far from the concept of institutions providing treatment for sick. These were pauper houses set up by parishes for the old, disabled, poor children and able-bodied unemployed to curb poverty. These were parish based, locally administered and small scale. The parish used to raise annual income based on property owned or rented to spend on the poor. As Rosen puts it, 'the hospital was essentially an instrument of society to ameliorate suffering, to diminish poverty, to eradicate mendacity and to help maintain public order' (cited in Baru, 1998). The state might have seen many advantages in letting voluntary and charitable methods deal with social problems. This is also because the state was not prepared to take up the welfare role in the dominant market economy that was prevalent. This approach avoided public admission that care was the right of the poor, rather than the gift of the rich. The story of the policies of charitable/voluntary institutions needs to be understood in relation to the politics of public welfare. The state expanded its welfare provisions not by creating a larger bureaucracy but rather by legislating into existence welfare requirements, provision of which was left to private bodies that were voluntary and had an edge over business groups (Barry and Jones, 1991). Medical charities were often held to represent good value for money, partly because of their long-term benefits and partly because they offered a very specific and closely regulated form of relief. Lane, (2001), says that hospital care, for example, could be subject to rigorous public rules of admission and methods of administration so that donors could sleep peacefully, assured that their money was being properly spent. Publicity issued by hospital boards highlighted the number of cases cured and treated and thereby aimed to legitimise and sustain the charitable impulse. ‘Curing’ was an important priority for many charities, donors and medical
practitioners and patients who shared beliefs of cure. Therefore, criteria for admission often excluded the incurable or those unlikely to be relieved, while a record of success was an important part of the propaganda of charity. Lane writes about 18th-19th century England and states that "in social terms a hospital became a focus of philanthropic efforts and subscribing was open to many who might not have participated in other activities. They were governed by persons who had contributed substantially and hence were in a position to determine admission policy. It was important that patients be 'deserving poor'. Only those admissions were allowed in these institutions that were curable. Infections, venereal diseases, children and pregnant women, mentally ill, chronic sick were excluded and outside the range of charitable appeal. One reason for these exclusions was that being able to cite good statistics for curing or relieving patients was an important aspect of gaining subscriptions. Admissions were restricted to short-term acute illnesses. This restriction was readily accepted by the medical staff, since it provided patients considered to be of interest for teaching and could be said to make the most efficient use of bed. There was constant concern of the running costs of hospitals. Accumulated figures of number of patients treated and at what cost were published so as to encourage rate payers by showing that their subscriptions were helping the poor to return to their work and they were not burdening the workhouse and increasing poor rate expense (ibid. 2001). By the beginning of 19th century, the local parishes were also issuing contracts between surgeons and apothecaries to provide medical care for the poor. The apothecaries had become physicians to the poor and middle classes.

**Industrial Revolution and the Redefinition of Charity**

Urbanisation is a key factor in redefining charity in the eighteenth and nineteenth century. The industrial revolution coincided with the establishment of manufacturing capitalism. By the 1830s the whole process of industrialisation was at its peak. As more and more factories came up, more number of workers was required in the cities. Following the Poor Law Acts of the 17th century, amendments were made to this act in view of the political and economic interest. Poor relief became harsher and more structured. The government felt it could not support all the poor anymore and assistance to all the able bodied poor was discontinued. This compelled them to move out of their rural homes in search of employment in the growing industrialised cities. The working class during this time formed a large proportion of the population in the urban towns and most diseases were prevalent among this section arising from their poverty. It became imperative to take care of the health of the working class in the interest of the state as their ill-health was affecting the economy.
In England, frequent epidemics brought in to focus the social conditions of the working class in cities of London, Manchester, and Leeds. It was no longer possible for individual practitioners to help the large number of people. Problems of overcrowding, congestion, improper sanitation resulted in growing incidences of communicable diseases. An ill working class meant low productivity and hence a weak nation. This is the time when Edwin Chadwick was appointed Secretary in the Royal Commission. To bring out the existing situation more clearly, Chadwick used large surveys to understand the social conditions of the working class. The outcome of the surveys called for immediate sanitary reforms as they showed associations of communicable diseases with filthy environment. Initially these surveys were restricted to London but soon it was spread out to England and Wales. Chadwick concluded that sanitary reforms were a must to bring about better living conditions which would then improve health status of the working class. Rise in death among the working class meant more widows and orphans who had to be then supported by state. Preventive steps in the form of sanitary reforms were taken up to improve living conditions of the labour force.

For most of the 19th century collective action and social science approach became of primary importance to deal with problems of public health. This was the miasmic era where social and economic conditions were seen as causal factors of disease and ill-health. Classical epidemiological studies and surveys during this time demonstrate the link between social and economic condition with disease. Among the people who conducted such studies was Snow’s study on cholera epidemic and Farr’s work on death of miners due to diseases of the lungs. They went beyond Chadwick’s reformist approach and searched for answers as to why more people from the poor class were being affected (Snow, J. 1989; Rosen, G, 1971). Rowntree was particularly interested in the problem of obtaining accurate measurement of energy requirements of the average working man in terms of calories. “The theoretical developments of dietics, biology, demography and eugenics were associated with a growing social and political concern about the impact of the working class on 19th century democracy which was still based on property ownership” (Turner, 1995).

Charity and charitable relationships permeated through the social fabric of this period. The 19th century debates on the merits of charity were also dominated by evolutionist philosophers like Malthusian and Darwinian philosophies, the main understanding being that the weak will perish and it is important for a strong future generation. Malthus was widely
An article by Cumming (1897) sums up the debates of evolutionist philosophers and how these views were internalised by the society. He states, "Philanthropy is present in the word on a new and gigantic scale. Everyday civilisation finds it harder to see the weak pushed to the wall. Philanthropy deals a twofold blow at progress. It not only perpetuates the weak: the essence of it is self-sacrifice of the strong to the weak. Thus the law of progress is reversed. Even science has joined the forces of degeneration. The deadly microbes of fever and contagious disease which have been such efficient allies in the work of rejecting the weak, are being banished from the earth."

Charity operated around the idea of deserving and undeserving poor i.e. being selective about whom to gift and whom not to. In England, the state too made these differentiations between the deserving and non-deserving as it did amongst the able and notable poor in their Poor Laws. The Victorian era put a lot of emphasis on the moral character of individuals in a society and hence the differentiation between the deserving poor and non-deserving poor. Gettleman (1963) on his work on charity and social classes in the United States says, "The worthy poor were considered those who have the strongest claim on sympathy....the silent, sensitive, painfully respectable people, whose clean and tidy rooms conceal to the utmost the evidence of their poverty. They must be sought out with delicacy and treated with the utmost courtesy." Much of the eighteenth and nineteenth century charity to the poor also suggests an awareness of reciprocal relationship in gift-giving. Between the donor and the recipient, the giving was obligatory and there was a clear unequal relationship between the two. Classics in literature written during this period by authors like Dickens and Bronte have given very vivid sketches of the relationships between the patron and the recipient as in Oliver Twist by Dickens where Oliver is reprimanded for 'asking for more soup' in the orphanage or in Jane Eyre where she is constantly reminded by her benefactors of the moral burden of receiving charity. In such a milieu there was not enough space to challenge the inequalities and charity was presumed to alleviate poverty. The distinct separation of classes was seen as an organism that was essential to the functioning of society and charity perpetuated these class differences. It was presumed that the recipient would reciprocate in actions that would reflect the generosity of the donor. Thus this period emphasised on institutionalised and informal behaviour modification in the charitable relationship and the generalised abhorrence of indiscriminate giving.

Although there was a significant increase in charitable hospitals, these institutions were unable to cope with the needs of a society undergoing rapid urbanisation and population
increase. The state intervened in an organised way for the first time to provide health services from mid-19th century, preventive measures were given priority. This in itself came about to restore public order by reducing illness, put the upper classes at peace by reducing their fear of infection that they thought they could contract from the poor and also the larger utilitarian principle that the state needed the working class to be healthy in order to participate in building the economy that was of utmost importance. In the area of curative services, as put by McKeown, “it was because the voluntary hospitals made the exclusions, the poor law had to emerge and had to develop its own hospital branch” (McKeown, 1971). Establishment of Poor Law hospitals was after 1834 in England, the first organised intervention by the state in building institutions of care and direct provisioning. Workhouses were created to end domiciliary aid for poor and to put to work the able-bodied poor who were considered to be the ‘undeserving poor’. Many poor houses were converted to asylums and hospitals. The state further intervened in providing health services for strengthening its military. Medical provision, training and knowledge were revolutionised by the Crimean War (1854-6), Boer War (1899-1902) and later the First World War (1914-1918). These wars demonstrated the state of health of the military in Britain. More people died of illness and infections in hospitals than the war. Separate infirmaries in 1867 were created as advocated by Florence Nightingale and earlier by Sister Mary Jones due to appalling conditions of the workhouse hospitals created under the Poor Law. The concept of hygiene and care in hospitals was revolutionised at this time and the nursing profession became more organised and gained importance. These wars made the state provide health services for the military as the voluntary hospitals were also unable to cope with the needs mass warfare and that of the society undergoing rapid urbanisation. Some nursing charities also emerged during this time.

Capitalism was favourable for the advancement of science and the late 19th century saw growth of institutions all over the world. “Despite its therapeutic ineffectiveness, the development of medical science was nevertheless of tremendous significance throughout the Victorian period” (Doyal, 1979). By the end of 19th century, the discovery of X-rays, blood groups, use of antisepsis techniques, discovery of the micro-organism enhanced claims by scientific medicine that specific diagnosis and treatment especially in forms of surgery was possible. With the coming of the germ theory, there was shift from the miasmatic understanding of disease to the germ in the body that resulted in the malfunctioning of the body can be identified and isolated. Notions of objectivity through observations and ‘seeing’ was viewed as conforming to the principles or methods used in science and this was considered progressive. For the medical community it was a giant leap. The reductionist
perspective with the coming of the bio-medical approach gained much importance with the focus on the germ rather than the social and economic causes. The traditional philosophy of public health lost prestige and power in the medical hierarchy. Medical solutions to 'cure' became the focus and the nursing profession also started getting organised and emphasised on 'care'. This resulted in the consolidation and growth of institutions. Presence of hospital encouraged practitioners, surgeons in the town. Surgeons gained a better status than the physicians by gaining hospital appointments and the emergence of the consultant class also took place at these times who were physicians with hospital appointments. The changing ideas of the medical profession about the potential of medicine, their professional interests and their political and social ideals resulted in a major shift. Initially, charities might have offered important opportunities to the medical profession, both to establish new types of medical care and to forge individual and collective reputations and many of these medical men came from the same social background and shared the political attitudes of those running the charities in which they practiced. These institutions also saw the changing patient profile when the middle class started entering them for treatment. Changing medical interests of the profession led to a gradual shift in the types of care offered, the motivations and interests. Hospitals gradually became more medicalised and depended on the profession than the influence of subscribers. The subscribers no longer could recommend patients and the selection of patients was based more on doctor’s recommendations. It became important for those in the medical profession to gain institutional appointments. The medical profession was gradually in the process of getting organised and gaining power all over the world. The changes in the hospitals in the nineteenth century were in important areas of medical teaching and the entire profession expanded as never before, the acute sick outnumbered the chronic and specialist hospitals emerged to provide new treatment (Lane, 2001). Doyal (1979) writes, “.....medical ideas, and the activities and pronouncements of doctors, were a very powerful social force, in the latter half of 19th century. This power arose from the ideological importance of medicine in defining and justifying new modes of social and economic organisation as well as from the growing significance of medical practice itself as a mechanism of social control”.

At the same time the modernisation of voluntary sphere was a complex process, reflecting political and social tensions in the later half of 19th century. Welfare measures by the state were not fully welcome by everyone. Socialised medical schemes were opposed by private practitioners. Comprehensive systems of state welfare were supported by secularising and politically radical forces. Conservatives clung to the virtues of discretionary charity.
There continued to be a broad range of voluntary activity despite the scientific leaps in medicine. The voluntary sector expanded as did state welfare. Germany and France especially offered alternative medical assistance schemes in forms of state insurance and family welfare schemes. Voluntary initiatives and church based institutions remained vital. Charity retained its space in the expanding welfare systems of the twentieth century (Weindling, P. 1991)

The development of the modern hospital as a centre for training doctors and promoting research i.e. development of hospital as a clinic owed a great deal to the transformation of the hospital system by the French Revolution. The emergence of the hospital as a clinic was the topic of an influential study by Foucault. Foucault recognised the existence of ‘proto-clinics’ from the seventeenth century but he argued that it was the reforms undertaken by the Comité de Mendicité which paved the way for a new empiricism in medical training, namely the birth of the medical gaze, and what followed was a new system of education (Turner, 1995). The distinction between physicians, surgeons and apothecaries in terms of status, training was no longer present in the 18th-19th century. The distinction was made between who had a hospital appointment and who did not have. Recognition was linked not with individual type of practice but through institutions. The Medical Acts of 1858 and 1886 were instrumental in removing the distinctions between the physician, surgeon and the apothecary. The distinction was between the general practitioner and the consultant: those not appointed by hospitals and those appointed by the hospitals. The general practitioner or the GP was termed as the country consultant and the consultants held a higher social status and a hospital appointment. The growth of medical dominance in the late 19th century and first half of 20th century was associated with urbanisation, emerging middle classes, the development of health insurance, improvements in medicine and the expansion of hospital as the site of scientific medicine.

Germ Theory of Disease and Growth of Hospitals During the late 19th and Early 20th Centuries

The growing importance of hospitals (state-run and voluntary) in the late 19th – early 20th century all over the western and colonised world, therefore, depended on – i) the medical profession that had secured a growing status and prestige within society as a consequence of development of medical science i.e. X-rays, antisepsis, anaesthetic for surgery and its successful organisation; ii) development of nursing profession and improvements in hygiene and sanitation thereby reducing mortality rates in hospitals; iii) emergence of middle class
clientele seeking institutional care; iv) significant improvements in insurance systems which brought hospital care within the reach of the middle classes through expanded insurance schemes; v) development of antibiotics meant less prevalence of infection in the hospital; vi) finally, the utilitarian principle of having a healthy population for a better economy by the state, gave impetus to institutional care.

The emergence of scientific institutions was critical to training of the medical profession and the pinnacle of biomedical effort. Teaching hospitals, larger voluntary hospitals, therefore, had a profound impact on practice of medicine. According to Cherry, in England they became research establishments and their increasing range of treatments impacted upon the nursing profession, hospital design and hygiene and cost-effectiveness, each a subject of reform by 1900 (Cherry, 1998). In England, the cost of medical care gradually was on the rise and became unaffordable and the poor who were chronically sick, infirm or infectious were unloaded on the Poor Law hospitals that were least equipped to deal with it as seen in the table below. Voluntary hospitals gradually started catering to the well-off and at a cost; the new medical developments were available to them. They became less philanthropic as traditional methods of funding stopped. Their new income was a clientele of donors at public collections, quasi insurance or community contributions and they resorted to direct charges from the patients.

The Royal Commission was set up in 1905 to examine the Poor Law. Two reports were brought out, the majority and the minority report. The minority report talked of a unified medical service system. They wanted to combine the Poor Law medical services with the public health services which would be administered by a National Health Department as part of a social security system (Rosen, 1971). This report was brought out mainly by Beatrice Webb who was a Fabian socialist. The notion of equity was strong in her report while trying to bring down the inequalities in a capitalist society. The social security system had to lead the unified, integrated national health services. The Majority report held a conservative view. They retained the Poor Law and introduced specific measures like unemployment and health insurance. This view represented the physicians' interest as working under local authority would mean lack of power which they would otherwise have through institutions. The opportunities to integrate preventive and curative components of health care were disregarded from time to time. The British Medical Association was not willing to come under a unified state provision. The National Health Insurance Act of 1911 was again a remedy for poverty with the greater economic interest of the state. It provided
income to the worker when sick and primary medical care. The worker, employer and state were contributing for the worker’s welfare. Doyal (1979) is highly critical of the insurance scheme, as there was no talk of providing medical care for all, with significant number of women workers who were not included in the scheme. It was not completely state provided and regulated but this scheme represented a compromise between the interests of the state, the medical profession and all those organisations providing medical care. The doctors did not want to lose autonomy by being paid state employees, at the same time voluntary hospitals wanted to retain their independence and the working class had to be brought within the purview of some welfare measures because of the growing demands of the labour movement. During the war period the state had to subsidise voluntary hospitals and direct fees were introduced for the middle classes (Cherry, 1998): “Many upper and middle class people found themselves compelled to enter public hospitals” (Eckstein cited in Baru, 1998). The methods used to finance the voluntary hospitals by many middle-class patients was seen as discriminatory, since the free care for the poor was dependent on payments made by them. The sick were further unloaded to the public hospitals. As can be seen from Table 2.2, there were more public hospitals for chronic and infectious diseases.

Against such a background and incremental involvement by the state for the survival of capital interests led to the genesis of the National Health Service (NHS) as a universal health services system post Second World War that was funded through taxation (Doyal, 1979). During the Second World War economic perceptions of Keynes and social policies of Beveridge influenced many. It encouraged the idea of ‘fighting for a new Britain’. The Beveridge report spoke of an effective social security system, full employment and a National Health Service. The report said that social security could not be provided unless there was a comprehensive health care service. The report held a reformist view and wanted to bring about reforms within the capitalist ideology. The NHS has been a comprehensive, unified scheme and has been humane service system but the genesis of NHS itself is a reflection of the wider social and economic structure of British capitalism (Doyal, 1979). The debates preceding the inception of NHS were the following: the doctors were concerned about their freedom as they did not want local government to have control on their medical practice; they did not want to be salaried state employees; and the consultants wanted to retain their work in the private sector. With these debates and disputes the NHS in 1948 came out with a different proposal than what was envisioned earlier. The NHS was organised into a tripartite system and was not all under local authorities. The three parts of NHS were- the hospital sector, the executive council sector and the local health authorities. The General practitioners retained
their freedom and were given contracts rather than made salaried employees. The consultants
gained a lot as they could work full time or part time with the NHS and could continue with
their private service. They retained their top position among the professionals. The hospital
sector was no longer under the local authority but was under regional hospital boards. The
local authorities were left with the environmental health services, health visitors, home helps,
midwives and district nurses. The hospital sector was dominant in NHS and had the power
and resources followed by the executive council and the local authority services became
insignificant. Resources were minimal with the local authorities and the organisation of
health services showed the decline of importance of public health measures and the emphasis
on individuals and the distinct separation of curative and preventive health care services
(Doyal, 1979).

All the 1200 voluntary hospitals were brought under the NHS. The state administered
and funded NHS was one of the significant outcomes of the welfare states that had emerged
in Europe post Second World War.

| Table 2.2 - The main categories of hospitals for the physically ill, by sector type, in England and Wales, 1861, 1911, 1938 |
|-----------------------------------------------|-----------------|-------|-------|
| Category                          | Sector          | 1861  | 1911  | 1938  |
| Teaching                          | Voluntary       | 23    | 24    | 25    |
| General                           | Voluntary       | 130   | 530   | 671   |
| General                           | Public          | -     | 76    | 133   |
| Infectious Disease                 | Voluntary       | 5     | 53    | 108   |
| Infectious Disease                 | Public          | -     | 703   | 931   |
| TB                                | Both            | 5     | 53    | 287   |
| Maternity                         | Both            | 12    | 8     | 411   |
| Special                           | Voluntary       | 72    | 121   | 175   |
| Chronic & unclassified            | Public          | 650   | 625   | 445   |
| Totals                            | Voluntary       | 254   | 783   | 1255  |
| Totals                            | Public          | 650   | 1404  | 1882  |

Source: Cherry, 1998

The National Health Service in 1946 inherited a collection of ancient and obsolete
hospitals, many of which had been built before 1861. However, there has been in the post-
war period considerable expenditure on the modernisation and development of hospitals in
the UK. The growing size and complexity of hospitals as medical settings has been associated
with the expansion of bureaucratic systems of professional administration. One indication of
this development of bureaucratic administration was the development in the UK of a
professional occupation of hospital administrators equipped with a system of entry by formal examination and a professional journal by 1945.

Evolution of Hospitals in North America

While Canada imported the poor law traditions from Europe, the separation of church and state was not as precisely drawn as in the United States. The divided linguistic and religious communities in British North America led to a "marriage of convenience" between the colonial administration and Catholic and Anglican Church leaders and gave religious authorities substantial power in shaping local poor relief. Colonial governments still held considerable centralised power, and the effect of confederation was to transfer the responsibility for hospitals to provincial governments, which in turn subsidised local public health initiatives and charity cases in voluntary hospitals (many of them church-affiliated). By the turn of the twentieth century, the blurring of the public-private divide in hospital care led to the development of a "single-tier" hospital system in Canada. Hospitals were for the most part self-governing, voluntary institutions that nevertheless relied in part on municipal funding derived from provincial subsidies; these subsidies reinforced the idea that the state had a benevolent role to play in ensuring entitlements to hospital care (Maioni, 2001).

Unlike the European model, the development of hospitals in US took a different path. For United States, the distinction between public and private philanthropy has been stark. Social welfare and public institutions in health care have been stigmatising as opposed to the non-stigmatising private philanthropy. Rosenberg explains this clearly through the case study of Philadelphia General Hospital that began as an almshouse in 18th century and evolved into a municipal hospital and closed down in the latter half of twentieth century. The hospital faced continued stigmatisation as a welfare institution. The almshouse was typically characterised by inmates who were mostly immigrants with no social base in the city, were very poor, dependent and/or sick and came here only as a last resort (Rosenberg, 1992). He argues that a significant motivation in the founding of private hospitals and dispensaries was the desire to maintain a distinction between the hardworking worthy poor and the almshouse's appropriate pauper residents. The rise of the non-profit hospitals was separate to that of almshouses and public hospitals and emerged as more important in the US than public welfare measures. Alexis de Tocqueville who wrote extensively on American institutions looks at the centrality of voluntary associations to American democracy, the role of business in 19th century charity organisation, the related growth of the welfare state and the non-profit
sector, and Ronald Reagan's policy of stimulating private institutions to take over government's role in social welfare. A careful historical analysis demonstrates that the third sector has been traditionally looked to as a fundamental source of diversity in American culture and society." (Hall, 1992).

In the United States local government were responsible for implementing relief measures such as municipal almshouses in the thirteen U.S. colonies and in the new states of the republic. By the first decade of 19th century every city had established an almshouse. Other than the almshouses, protestant religious sects also initiated private philanthropic institutions that provided both physical care and moral education. After 1850s there were other religious sects that established their hospitals- these were mainly by the Catholics and Jews. For most of American history, Jews used philanthropy and above all Jewish hospitals - to take care of fellow Jews, improve relations with non-Jews, counteract anti-Jewish stereotypes and prejudice, and provide enclaves from anti-Jewish discrimination. In the older cities of the East, the denominational hospitals came after the voluntary and municipal hospitals while in the Far West and South, Civil War had its after effects and private capital was less and they relied on the profit making sector in hospital making. The greater accumulation of capital in the older cities i.e. Eastern cities aided the creation of early voluntary hospitals (Starr, 1982).

There were variations in terms of the structure of the institutions and the kind of patients they catered to and methods of finance- the largest institutions were the elite voluntary and the municipal hospitals. There were strict admission rules that excluded many potential patients. The voluntary had the very poor (for teaching and research) and the very rich patients (for endowments and hope of revenue) and the public hospitals had only the poor and treated all ranges of people-from acute to chronic. The mix of classes in voluntary hospitals had to be kept alive so as to get the charitable donations. There were regional variations in the presence of these institutions and the most important dividing line among hospitals was ethnic and religious. Rosenberg (1992) sees a distinct difference between almshouse and voluntary hospitals in 19th century America that also reflected the values and class difference in society. The creation of private dispensaries was not simply a humanitarian gesture, but was seen as a rational means of saving the worthy poor from the degraded status of almshouse inmate. The voluntary hospitals had the ability to pick and choose among their cases and almshouse hospitals were seen as last refuge. The almshouse were therefore, typically representative of the city's poor while the voluntary hospital was
selective. The voluntary hospitals were unwilling to take the chronic cases and these cases filled up the public hospitals.

The period following the Civil War resulted in reduced role for the State and was characterised by the growth of corporations and large industries. The medical profession had reorganised itself by the beginning of the 20th century and were constantly defeating the passing of bills in the Congress that stated any kind of a national health services programme. Commercial insurance systems had started in a scattered way to cater to the local population. This change happened between 1870 and 1910 and was the beginnings of the for-profit interests in medical care. Starr (1982) observes that the social transformation of medicine in the American context was prompted by several factors other than scientific advancements. These included 'social and economic conflict over the emergence of new hierarchies of power and authority, new markets and new conditions of belief and experience'. Institutional structures of medical care also emerged as a result of authority that translated into control over science and technology and into arenas of social and economic power and influence. The medical profession itself had emerged from occupying a weak status to one of authority that influenced markets and government policy. The institutions projected ideals of specialisations and technical competence. It also brought about changes in internal organisation.

Changes in organisation and private financing in United States gradually altered the distribution of power and authority in hospitals. Authority gradually turned from trustees to physicians and administrators. Old rhetoric of charitable paternalism was superseded by a new vocabulary of scientific management and efficiency. Three power centres emerged—physicians, trustees and administrators and while the working class demands were weak these three centres created space to shape their interests. The growth of the insurance market helped organise the private interests from all sides. Importance was given to hospital administration because of little centralisation of functions in the society and more with the hospital. Starr (1994) also sees cultural heterogeneity as a major factor that has inhibited the consolidation of hospitals into a state-run system in the US.

In the US in the 1970s, restrictions were imposed on hospitals organised for-profit that resulted in generating a trend towards non-profit organisations. Small proprietary hospitals started disappearing. Bays (1983) argues that the trend towards non-profit hospitals is not explained by the failure of the health market and neither is it the result of a desire to
serve the public interest more effectively. Several factors have had direct negative impacts on for-profit hospitals over the period of their decline. Total capital costs were higher for the for-profit because they had not benefited from the private philanthropy and government subsidies had been provided to the non-profits. Labour costs were higher in the former due to preferential treatment of the non-profits in the labour laws; they had to pay higher taxes and they had not enjoyed the preferential legal status. For-profit sector reached its peak in the 1930s but gradually a large number of hospitals disappeared. The non-profit hospitals became more dominant because physicians as a group preferred it because favourable tax treatment and subsidies by government lowered the total cost of the hospital inputs (Bays, 1983).

The role of the state in bringing in private players in health services in United States is of utmost significance throughout. The Republicans were always in favour of a privatised health service system unlike the Democrats who tried to bring in place a nationalised system. Justification of for-profit business in health care was becoming an emerging ideology in United States since the beginning of 20th century. Various types of businesses in health services- pharmaceutical and medical device industries, laboratories, for-profit insurance, and hospital associated business were helped by permissive government policies. The non-profit hospitals had to therefore, respond to these for-profit forces that dominated the scene.

Liberalisation and After

The present era is characterised by deregulation and marketisation of society and economy. The changing role of the state in financing, providing and regulating health services has been a matter of much debate in the recent years. The cutting down of costs by the state in social sectors across the world, increase in the role of private sector and introduction of market principles in the public sector has resulted in changes in institutional structures.

The era of commercialisation has brought numerous shifts and changes to the definition of non-profit hospitals. These institutions have found it increasingly difficult to sustain their charitable character in a dominant market economy and demands made by the medical profession and the middle and upper middle classes. Many scholars debate on the converging character of the for-profit and non-profit in the West due to their perceived commercial character. This non-profit status in the present context is centrally concerned not with poverty relief but rather with property ownership. Significantly, it is a form of private
ownership and no private individual owns non-profit health care assets. But neither does the state or the communities that non-profits serve. Rather, non-profit assets are held in a manner akin to a trust, dedicated to serving a particular purpose that the state has deemed charitable.

In England, during the Thatcher regime, the NHS was privatised to certain extent and medical care was further privatised in United States under Reagan. Both were from the Conservative political ideology. This was a 80s phenomenon when markets were allowed to enter the social sector. The state-run hospitals in Britain have been made autonomous by having a separate management system in place though they are funded through taxation. Several types of partnerships have been introduced with the private sector like contracting out. The hospital systems have been converted to trusts. The trusts are in effect public sector corporations but maintain autonomy and compete with each other. In the US, although non-profits still have about two-thirds of the market for health care, for-profit companies captured almost all the growth in hospital and home healthcare during 1977–96, as well as expanding their share of the social services market in child welfare, including day care, and drug treatment (Kramer, 2000). This has had implications for the non-profit sector which has survived by transforming itself. In the US, 70 percent of the beds are in not-for-profit sector (David, 2004). By definition these institutes are exempt from taxes and enjoy certain subsidies from the state but in the US even though they are not participating in the stock market as their for-profit counterparts, they are integrated in a profit making market system. Medical care is dominated by the private health insurance systems and managed care organisations. On the other hand, in Canada 95 percent of the hospitals are non-profit and they function in a state financed and regulated environment.

Though the notion of ‘risk’5 has been present since the advent of capitalism it is more characteristic of a society in recent years with the increasing deregulation of the market place and the resulting uncertainty of social and economic conditions. The developed countries have also been increasingly facing problems of elderly needing care and an increase load of chronic diseases. In these circumstances, the understanding of causation of disease has also seen a shift from clinical epidemiology to the risk factor epidemiology. This understanding is also linked to the epidemiological transition in the developed parts of the world where the

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5 Beck (1986) states that within the capitalist context, risk has to be seen as a consequence of production of wealth, transformation of society and institutionalisation of scientific knowledge. To control risk there is reorganisation of power and authority in society. He says, “Risk is a systematic way of dealing with hazards and insecurities induced and introduced by modernisation.” He argues that there is a shift from production and distribution of goods to a concern with the minimisation and prevention of ‘bads’. The practice of risk assessment and risk management are therefore an essential feature of modern society.
greater burden of disease is non-communicable. According to Yadavendu (2003), the object of risk factor epidemiology is to promote awareness of potential dangers unleashed by individual lifestyle choices. As society gets more individualistic, keeping oneself healthy is perceived to be an individual responsibility and depends on the risks one is taking. The shift from the miasmatic understanding and laboratory perspective of the germ theory to the individual has now been further reduced to the molecular dimension. This understanding has given rise to further institutionalisation of knowledge by developing new research institutions, further development and investments being made on new technologies and more power and authority to the medical profession.

The non-profit sector has received more prominence from the legal and economic point of view in recent times. Non-profits no longer exist entirely on donations and no longer cater primarily the poor. There is heterogeneity in their character and enormous variation in their source of funding. Non-profits in a mixed economy are not free from market pressures. Whether non-profits can survive without being indistinguishable from for-profits requires looking at the changing markets in which non-profits operate. Similarly charitable hospitals have redefined themselves as non-profits and have shifted dramatically in their role and function. The changing socio-economic context brings out similarities as well as variations in experiences across countries in this sector.

The idea of hospitals that took shape in England got translated to their colonies and the institutions that emerged in the latter, India being one of them. The following chapter will look at the non-profit sector in health care in India.