By the Community, For the Community?

The Transfer of Hospitals from State to Charitable Control

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1. **Abstract** (173 words)

During decades of UK healthcare reform and rationalisation in which hospital services were concentrated into fewer, larger buildings, hundreds of small hospitals were closed sparking community backlash and campaigns against closures. In nine cases, from 1984 to 1998, these campaigns resulted in the hospitals leaving the state-provided, taxpayer-funded National Health Service to become charity hospitals. Rather than closing permanently, these hospitals took on new organisational forms, under the management of purposely-established charitable trusts. Examining how and why these transfers took place, we analyse extensive archival and newspaper records, political transcripts, and contemporary documents related to the hospital campaigns. Framing insights with Resource Mobilization Theory, we explore (1) the different types of resources mobilized during these campaigns and how, and (2) the different types of communities involved in the campaigns and their distinct motives. Findings highlight the importance of social capital, effective representation, and campaign leaders. We contribute a typology of ‘communities’ involved in these campaigns and community philanthropy efforts to ‘save’ their hospitals from closure and support their ongoing operations outside the NHS.

**Main text** (7,838 words)

1. **Introduction**

In the 1980s and 1990s, nine hospitals in England left the state-provided, tax-payer funded National Health Service (NHS) and returned to their pre-NHS status of charity hospitals (Mohan & Gorsky, 2001). Each of these small hospitals were due to be closed in the NHS immediately prior to their transfer out of the NHS; rather than close, these hospitals adopted different models of ownership and control. These are the only hospitals known to have made such an institutional change in the UK. Yet, despite their unique nature, they remain unexamined. Addressing this, we explore how and why these transfers took place.

These hospitals transferred followed decades of NHS reform aimed at increasing the efficiency of the Service. The 1962 Hospital Plan for England and Wales proposed, over a period likely to extend into two or three decades, to construct 90 new and 134 substantially remodelled hospitals into which most services would be concentrated (Mohan, 2012). The corollary was the proposed closure of some 700 hospitals – mostly small and serving small towns or rural areas – in the guise of efficiency and patient safety (Mohan, 2002). The 1976 Resource Allocation Working Party (RAWP) was designed to redistribute NHS resources to better match patient needs. As a result, previously advantaged areas (e.g. London, where there was substantial “overprovision” of resources as a consequence of the city’s historic generous inheritance of charitable institutions) faced significant budget cuts, leading in some cases to closures and reduced services (Gorsky & Millward, 2018; note that the definition of ‘overprovision’, and therefore the need for redistribution of resources, was exhaustively contested). From 1979, a series of successive Conservative governments in the UK pursued rationalisation of the NHS, introducing market forces and private sector rationales to drive efficiency (Brown, 2003). They were also actively open to alternative NHS funding sources beyond taxation, including through the voluntary sector (Jenkin, 1979). In 1979, then Health Minister Patrick Jenkin stated: “We are always prepared to discuss with health authorities and voluntary bodies the way in which voluntary funds can supplement valuably the work of the National Health Service. We are prepared to discuss in some cases the question of leasing hospitals at peppercorn rents to voluntary bodies to run themselves rather than that they should be closed” (Ibid, col.1798). It was against this backdrop of hospital closures (particularly of small hospitals), cuts, centralization of services, and explicit support for voluntary action, that nine hospitals transferred from the NHS to charities.

In this paper, we first explore the literature on hospital closures and campaigning, identifying the multiple sources of meaning and significance hospitals hold for their communities, and the ways in which communities have opposed efforts to close part or all of their local hospital. Second, we examine Resource Mobilization Theory (RMT), used to frame discussion in this paper. Third, we outline the multi-case study method adopted and the extensive data collected for all nine of the hospital cases. Fourth, we present findings from examining and comparing these hospitals, distinguishing between (1) the different types of communities involved in the campaigns and their distinct motives, and (2) the different resources mobilized during these campaigns and how. Fifth, these findings are framed and explored in relation to RMT, discussing their relevance for community philanthropy and health policymaking. This paper contributes: extensive empirical insights into nine unusual but as yet unexplored cases of collective action; understanding of how community philanthropy may be used not just to support established nonprofit organisations but also to establish new nonprofits; a typology of the different ‘communities’ involved in social movements and community philanthropy; and development of Resource Mobilization Theory within the context of healthcare-related nonprofit organising.

1. **Hospitals and their Communities**

The significance of hospitals for their communities extends far beyond the provision of clinical services: hospitals and communities exchange and co-produce resources, values, and meanings in a symbiotic relationship (Stewart, 2021). Hospitals are embedded in and entwined with the communities in which they are established and run. As such, they are deeply connected with local identity and people’s ‘sense of place’ (Jones, 2015; Brown, 2003), a source of “meaning and familiarity” for the publics they serve (Kearns, 1993, p.140).

Given many hospitals in the UK were originally established by local people and financially sustained by their donations, legacies, and subscriptions (Gorsky & Mohan, 2001), many communities feel a sense of ownership of their local hospital (Jones, 2015). This is reinforced and amplified by ongoing community support for hospitals: even under the National Health Service (NHS), communities continue to support their local hospitals with contributions of money, time, and voice (Ellis Paine et al., 2019). These activities are fundamentally social: hospitals are social hubs at and around which social activities, not necessarily related to medical needs or provision, take place (Kearns, 1993; Brown, 2003).

Hospitals are further imbued with different sets of values. In addition to being seen as sites of healing and healthcare, hospitals within the NHS are also associated with the principles of fairness and equality upon which the NHS was founded (Jones, 2015). Thus, NHS hospitals have at least two identities: on a local level, hospitals are perceived as locally-owned resources connected with their community identity; on a national level, each hospital is perceived as representative, and a part, of a national system owned by and accessible to the whole population, not just the local community.

Hospitals are also a source of local employment: 1.2 million of the 1.5 million people employed by the NHS work in ‘hospital and community services’ (Rolewicz et al., 2022). In some cases, hospitals are the main employer of a town or area, with a significant portion of the local population employed at the hospital (Maguire, 2020). This economic significance creates another layer of a community’s connection to, and dependency on, their hospital.

It is due to these social and economic ties and symbolic significance, that plans to close, merge, or downsize hospitals are often met with strong resistance. Restructuring proposals have often been met with opposition from local communities in the form of ‘save the hospital’ campaigns, featuring protests, petitions, calls for public inquiries, and political lobbying (Brown, 2003). Some communities have adopted extreme measures to further their campaigns against changes to hospital services. For example, in the case of Kidderminster Hospital, where the accident and emergency department was closed in 2000, a new political party (the Independent Kidderminster Hospital and Health Concern) was established. Largely campaigning on the sole issue of restoring cut services at the hospital, the party won a majority of seats on the local council, and successfully elected one member to the House of Commons in 2001, and again in 2005 (Brown, 2003; Oborn, 2008). In the nine cases examined in this paper, community opposition to planned hospital closures eventually led to those communities taking on the management of their hospitals themselves through the establishment of a new charitable trust.

The format and focus of campaigns against hospital cuts and closures has changed notably over time. During the 1960s and 70s, campaigns focused on the perceived utility and characteristics of individual hospitals, rather than broader visions of the NHS as a whole (Crane, 2018a). From the 1980s onwards, campaigns against hospital closures defended both the identity and value of individual hospitals *and* the NHS, as hospital closures were connected to wider NHS policy and budget cuts (Ibid). At times, the fact that many of these institutions were initiated through the voluntary efforts of communities in the 19th and early 20th century has explicitly been invoked (Mohan, 2002), so in some respects it is surprising that proposals to transfer hospitals back into community ownership have been relatively rare.

1. **Resource Mobilization Theory**

To examine the campaigns related to the nine hospitals explored in this paper, we use RMT. RMT has been used to examine social movements – a form of collective action organised around a shared set of beliefs towards changing something in society (McCarthy & Zald, 1980, 2003) – including campaigns against hospital closures (e.g. Barker, 2017). RMT focuses on how resources are intentionally mobilized by and within a social group or groups in pursuit of a collective goal. It stands against classic conceptions of collective behaviour as social contagion, and mass society theory which views participants of collective action as isolated individuals (Tindall et al., 2008).

* 1. *How are resources mobilized?*

RMT posits that resources are essential for collective action (Buyantueva, 2020). Edwards and McCarthy (2004) present a typology of five types of resource used by social movements: moral, cultural, social-organizational, human, and material.

Moral resources refer to support for the goals of a social movement, including, for example, perceived legitimacy of the cause, support from community groups, and endorsement from celebrities (Edwards & McCarthy, 2004). In US-based research, Mick et al. (1993, p.115) found that, when facing closure, rural hospitals undertake “various legitimising activities – garnering community support and cohesion and engaging in other non-economic activities like legislative lobbying”. Moral resources are accessed from sources outside of a social movement from external groups or individuals and can hence be withdrawn (Edwards & McCarthy, 2004).

More widely available than moral resources, cultural resources include practical know-how, specialized knowledge, and particular skills (Edwards & McCarthy, 2004). Cultural resources can be held within or produced by members of a social movement, such as publications and platforms promoting the movement and its goals (Spier, 2017). They include, for example, experience and knowledge of engaging in activism and organising events. Such experience provides templates for future action (Edwards & McCarthy, 2004).

Social-organizational resources include infrastructures (e.g. internet, postal service), social networks, and organizations (Edwards & McCarthy, 2004). In campaigns against hospital closures, health councils have often played significant roles (Abelson, 2001; Crane, 2018b). In the UK, Community Health Councils (CHCs) were established in the 1973 NHS Reorganization Act, each responsible for a local health authority area with a population of up to half a million. They were intended to represent the interests of the public living within the area it covered. Health authorities were required to consult with CHCs about possible hospital closures; if a CHC objected to a planned closure, they were required to submit a counter-proposal (Department of Health and Social Security, 1974).

Human resources are the skills, labour, and expertise embodied by people involved in the social movement, e.g. volunteers, leaders (Edwards & McCarthy, 2004). Campaign leaders are especially important. Described as ‘social movement entrepreneurs’, leaders have unique knowledge and abilities to mobilize resources (Bräuer, 2008). Research has further highlighted the prominent role that local health professionals often take in resisting hospital closures (Barnett & Barnett, 2003).

Finally, material resources are economic, primarily financial and physical capital such as grants and donations given to the movement, and in-kind gifts such as access to office space or equipment (Edwards & McCarthy, 2004). Money is an especially valuable material resource as it can be exchanged for other resources (ibid).

* 1. *How are resources mobilized?*

Resource availability in a community drives the size and shape of the nonprofit sector, including the number of nonprofit organizations (Grønbjerg and Paarlberg, 2001), and levels of philanthropic giving (Bekkers & Wiepking, 2011). However, level of resources alone does not determine the success of collective action (Edwards & McCarthy, 2004): just because individual members of a community may be rich in resources, does not mean that they will use them to pursue the collective needs of the community. The success of collective action, from an RMT perspective, is a result of both the availability of resources and the collective ability of a community to mobilize those resources in pursuit of shared objectives (McCarthy & Zald, 1973; Edwards & McCarthy, 2004).

Edwards and McCarthy (2004) posit there are four ways resources are accessed: aggregation – combining and coalescing of resources from the individuals comprising a social movement; self-production – internal production (or enhancing the value) of resources within a social movement; co-optation – the consensual borrowing of resources aggregated by the movement; and patronage – gifting of resources to the social movement (can come with stipulations over how resources can be used). Across these, the ability to accumulate resources through these different channels depends on the political context and cultural factors (Garcia & Parker, 2011).

Research examining ‘community’ opposition to hospital closures has highlighted heterogeneity: though reported ‘public’ response is typically negative, public perspectives range across a spectrum of for and against planned change, with different levels of involvement in campaigns (Kirouac-Fram, 2010; Barratt et al., 2015). Blanket descriptions of ‘the public’ therefore ignore competing views held and actions taken by different public groups and individuals, as well as the capacity for these to change over time (Stewart, 2019).

Broadly, RMT distinguishes between four types of people in relation to social movements: opponents – those who do not agree with the movement’s goal(s); bystanders – those who witness a social movement without ascribing support for or objections against the movement’s goal(s); adherents – those who agree with the movement goal(s); and constituents – those who provide resources in pursuit of the goal(s) (Bräuer, 2008). To succeed, social movements must convert bystanders and opponents into adherents, and adherents into constituents.

In generating adherents, media attention is key: through public awareness initiatives the campaign’s goals and mission are disseminated in an effort to build consensus around them (Edwards & McCarthy, 2004). Social movement leaders and constituents play an important role in framing a phenomenon as a social problem, generating collective acceptance of this frame, and building support for a desired resolution to the problem (Snow et al., 2019). Multiple social movement initiatives may emerge around any given social issue and these do not necessarily collaborate or share the same frames. For instance, examining the Booth Hall Children’s Hospital which faced potential closure in 1993-94, Barker (2017) highlighted the roles and activities of two separate campaign groups who, despite both wanting to prevent the closure of the hospital, had opposing campaign ‘frames’ and rarely coordinated activities, remaining independent from one another.

Converting adherents to constituents is achieved through encouraging, and providing opportunities for, practical contributions and action, such as through appeals for financial contributions or petition signatures. Co-optation of social-organizational resources is particularly useful in this regard, using pre-existing relationships with networks and organisations whose members are already, or are more likely to be, adherents to the movement, and who can therefore mobilize their own membership base in support of the movement (Edwards & McCarthy, 2004).

* 1. *RMT and community philanthropy*

RMT has been used to examine community philanthropy – a form of collective civic action in which individuals jointly mobilize resources in pursuit of a shared desire to address (a) local issue(s) (Hwang & Young, 2020). Through community philanthropy, resources are typically mobilized for “community-based nonprofit organizations that deal with local social problems” (Ibid, p.435). In this paper, we approach the cases examined as examples of community philanthropy; the nonprofit organisations in question are the nine hospitals which faced closure before transferring out of the NHS. Through the campaigns against their closure, and subsequently taking on the management of the hospitals themselves, the communities we explore engaged in community philanthropy. The primary perceived advantage of community philanthropy is that it shifts governance about local matters from remote state bodies to local communities (Wu, 2021). However, not all communities have the same capacity to take on responsibility for addressing local issues themselves (Paarlberg & Yoshioka, 2016), as resources are not equally distributed across communities (Edwards & McCarthy, 2004).

In this paper, we examine the nine hospitals that left the NHS to become charity hospitals, focusing on the campaigns against the planned closure of these hospitals and how and why these resulted in transfer instead of closure. Drawing from the insights afforded by RMT (plurality of resource types and mechanisms of mobilization) and the literature on hospital closures (evolving heterogeneity of 'community’ responses), we focus on:

1. What resources were mobilized and how?
2. What communities were involved in mobilizing these resources and why were they driven to do so?
3. **Methods**
	1. *Case studies*

We adopted a case study methodology, examining all nine hospitals known to have made the transfer from NHS to charity hospital. Exploring multiple cases enables comparison between each case (Yin, 2018). The nine hospitals examined (Table 1) were identified by Mohan and Gorsky (2001). No other hospitals following this move from NHS to charitable control have since been identified.

Table 1.Summary of the nine hospitals examined. Hospitals listed in order in which they transferred to charitable control.

|  |  |  |  |
| --- | --- | --- | --- |
| **Hospital** | **Location** | **Year Opened** | **Year of Transfer** |
| Tadworth Court (now The Children’s Trust) | Tadworth, Surrey | 1929 | 1984 |
| Hoylake Cottage Hospital  | Hoylake, Wirral, Merseyside  | 1905 | 1984 |
| Mildmay Mission Hospital  | Bethnal Green, London  | 1877 | 1985 |
| Tarporley & District War Memorial Cottage Hospital  | Tarporley, Cheshire  | 1919 | 1987 |
| Holbeach & East Elloe Hospital | Holbeach, Lincolnshire  | 1906 | 1988 |
| Brackley Cottage Hospital  | Brackley, Northamptonshire  | 1876 | 1990 |
| Tetbury Cottage Hospital  | Tetbury, Cotswolds  | 1868 | 1992 |
| Rye, Winchelsea & District Memorial Hospital  | Rye, East Sussex  | 1919 | 1995 |
| Odiham Cottage Hospital  | Odiham, Hampshire  | 1910 | 1998 |

* 1. *Data sources*

The primary data sources for this study are archival and newspaper records relating to each hospital’s background and transfer period. Archival records were identified by searching all known variations of each hospital’s name in *Discovery* – the search engine of the UK’s *The National Archives*. Newspaper records were identified by searching all known variations of each hospital’s name in *The British Newspaper Archive*, *Times Digital Archive*, and *The Independent Historical Archive 1986-2016*, ensuring widespread coverage.

These were supplemented with political records, contemporary websites, and videos. Several of the cases were debated in the UK House of Commons and/or House of Lords. Transcripts of these debates were identified and examined using *Hansard* (the official record of the UK Parliament). All nine hospitals have a website – we examined every primary and secondary navigation tab for each (excluding ‘contact us’ pages and staff profiles). Videos – primarily news reports on the campaigns against hospital closures, and short documentary-style videos recounting the journey to transfer – were identified by searching all known variations of each hospital’s name in YouTube. Only videos relating to the closure and transfer of the hospitals were included.

A summary of data collected and examined for each case is provided in Table 2.

Table 2.Summary of data sources examined for each case.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Hospital** | **Archives** | **Newspapers** | **Hansard** | **Website** | **Videos** |
| Tadworth Court (now The Children’s Trust) | 45 documents | 36 articles | 32 references; 2 debate titles; 31 written answers | 50 tabs | 5 videos |
| Hoylake Cottage Hospital  | - | 100+ | 1 reference; 2 written answers | 17 tabs | - |
| Mildmay Mission Hospital  | 108 documents | 17 articles | 19 references; 24 written answers | 15 tabs | 5 videos |
| Tarporley & District War Memorial Cottage Hospital  | 21 documents | 38 articles | 6 references; 37 written answers | 12 tabs | - |
| Holbeach & East Elloe Hospital | - | 68 articles | 5 references; 5 written answers | 12 tabs | - |
| Brackley Cottage Hospital  | 23 documents | 100+ articles | 1 reference | 6 tabs | - |
| Tetbury Cottage Hospital  | 39 documents | 100+ articles | 3 references; 1 debate title | 20 tabs | 1 videos |
| Rye, Winchelsea & District Memorial Hospital  | 12 documents | 14 articles | 1 written answer | 11 tabs | 6 videos |
| Odiham Cottage Hospital  | 5 documents | 100+ articles | 2 written answers | 5 tabs | 1 video |

All data was coded inductively (based on repeated patterns identified) and deductively (using resource types identified under RMT). Data was analysed using a thematic approach (Guest et al., 2012): all data was examined and interpreted iteratively in relation to the literature on hospital closures and RMT, the context in which the transfers took place, and the rest of the data set.

1. **Findings**
	1. *Facing closure*

All nine of the hospitals we examine transferred to charitable control when facing closure in the NHS – transfer came as a last resort to avoid permanent closure of the hospital. In no instance was the hospital transferred due to proclaimed benefits of voluntary versus state provision. In every case, the underlying reason for the hospital’s planned closure was financial – through various iterations of budget cuts, rationalisation of the NHS, and concentration of services on larger hospitals, these small hospitals were deemed uneconomic. All nine are small hospitals (i.e. fewer than 100 beds), and most are rural – the exception being Mildmay Mission Hospital which is in London.

The health authorities’ decision to close each hospital typically came after a lengthy process of cuts and restrictions over time, with closure coming at the confluence. For example, at Mildmay Mission Hospital, services had been gradually reduced following prolonged post-RAWP budget cuts from the local health authority. These cuts made the hospital less attractive for doctors and nursing staff; as senior staff left or retired they were not easily replaced (Royal London Hospital Archives, RLHA, 1992). With less services and less staff to supervise trainees, the hospital’s certification as a training hospital was withdrawn by the Royal College of Physicians, reportedly making it even harder to recruit staff. A ward was subsequently closed due to safety concerns over insufficient staffing. This vicious circle of reduced budgets and services, decreasing staff, and ward closures which further reduced services paved the way for the health authority to announce the closure of the hospital in 1982 (Ibid). This is illustrative of the nine cases examined.

In at least two cases (Tarporley and Odiham), the hospitals had faced threats of closure before the 1980s and 90s. In 1962, following the introduction of the Hospital Plan, Tarporley faced closure alongside many other cottage hospitals in the country. This was opposed by the local public and hospital staff who threatened to establish an independent hospital outside of the NHS if Tarporley was closed (Cheshire Archives, 1962). The hospital remained open as it was, also surviving subsequent closure threats in 1971 and 1976 (Cheshire Archives, 1971-99). Odiham Hospital similarly faced closure in 1968 to which Odiham residents responded with a successful ‘save our hospital’ campaign. In 1978, the local health authority planned the temporary closure of Odiham Hospital due to difficulty filling staff vacancies. A small committee was established to oppose the proposal, 600 people attended a public meeting, and the necessary staff were recruited, avoiding the need for closure (temporary or otherwise) (Wellcome Collection, 1999).

* 1. *‘Community’ opposition*

In each of the nine cases, there was no single ‘community’ response to the proposed closure of the hospital in question. Examining the different responses, we identified four different types of community: place-based, need-based, experience-based, and identity-based. Whilst there is overlap between the constituents of each community, they can be distinguished by their different perceptions and portrayals of ‘their’ hospital and reasons for wanting to keep it open. These themes were similar across the nine cases, except for identity-based communities which were identified only in the case of Mildmay.

Place-based communities.Place-based communities are defined geographically based on their proximity to the hospital. They hence include people living within the surrounding towns and neighbourhoods serviced by the hospital (e.g. residents of Hoylake supporting Hoylake Hospital). These communities defended their hospital as a local asset: campaign posters, signs and flyers read ‘Save *our* hospital’ and ‘Don’t let them close *our* hospital’ (emphasis added), indicating a perceived sense of ownership. As summarised by one individual campaigning against the closure of Rye Hospital: “They have no right. It isn’t their building, it’s our building” (Cobley-Jones, 2021). This quote is illustrative of the place-based communities across all nine cases. Requests for campaign support often drew on this sentiment, appealing, for example, “Save YOUR Hospital”, and “Tarporley Hospital will close without YOUR help” (emphasis in original) (Cheshire Archives, 1981-84). These appeals for action aimed to turn campaign adherents into constituents.

All nine hospitals predated the NHS, founded and supported by local communities through voluntary action. As well as symbols of local charity and philanthropy, these hospitals were portrayed as elements of local history. This was particularly the case for Tarporley and Rye which were established as war memorials after the First World War. In Rye, the names of the local people who had died during the War were displayed on a wall in the hospital. These memorial foundations were raised by local campaigners when the hospitals faced closure, calling the closure “disgusting” and disrespectful to the memory of those who had died (Cobley-Jones, 2021).

Need-based communities.Need-based communities shared a need for the services provided by the hospitals. In our study, these included (in- and out-) patients at the hospitals examined, as well as their families, guardians, and carers. These communities defended the hospitals as local facilities which – owing to their location within the towns in which they lived – were more easily accessible than larger general hospitals. For example, Tarporley Hospital was defended by campaigners as more conveniently-located than alternatives: “travelling to Chester or Crewe just for a dressing – with travelling and waiting it becomes almost a day event” (Cheshire Archives, 1980). In the case of Rye, support for the campaign to retain the hospital increased after a Rye-based teenager passed away from an asthma attack whilst en route to a larger hospital following the closure of the Accident and Emergency department at Rye (Moreton, 1995).

Tadworth is an exception to this trend: as a specialist children’s hospital, most patients were not from the local community. It was therefore never defended in terms of local accessibility but rather in terms of its medical specialty as a key provider for children’s healthcare. Tadworth provided respite care to disabled children and their families. As patients were children, this defence primarily came from parents of patients and other representatives of children’s healthcare such as children’s charities. For example, Dafydd Wigley (Member of Parliament for Caernarfon) whose children had stayed at Tadworth and who had used the respite care provided there, argued the closure was not “in the interests of the consumers” (Wigley, 1982, col.624). The provision of respite care was portrayed as enabling children to remain living with their families in their own towns during the rest of the year.

Experience-based communities. We use experience-based communities to refer to those individuals and groups with experience of being in or a part of the hospitals such as current and former patients, current and former staff, and voluntary supporters. This collective was often described across the cases as the ‘hospital’ community – those who together comprise the organisation. Experience-based communities predominantly defended the hospitals in terms of their ‘atmosphere’: because the staff, patients, and supporters of the hospitals typically stemmed from the towns in which the hospitals were located, there was a sense of ‘neighbourly kinship’ between them. For example, Tarporley was described as providing: “a high degree of community care where patients are looked after by their own doctors’ and nurses who come from the local community” (Cheshire Archives, 1980a, n.p.). Even at Tadworth, where patients were typically not from the local community, the atmosphere within was still described as a ‘second home’, with campaigners asserting “its own unique atmosphere and very special qualities will earn it the right to life” (Surrey Archives, 1983, p.69). The economic argument for closing these hospitals was viewed as insufficient reason to ‘destroy’ this atmosphere and hospital community: “Arithmetic doesn’t deal with all the factors” (RLHA, 1983a, n.p.).

Experience-based communities often contrasted these small, local hospitals with what they perceived as ‘impersonal’ larger hospitals. For example, as one former patient of Mildmay wrote about the larger Royal London Hospital: “Ample testimony was given to the impersonal dehumanising effect of being just a “case” in that vast conglomeration”. By contrast, they described Mildmay as “intensely personal and caring” (RLHA, 1983b, n.p.). Tarporley was similarly defended when it faced closure in 1971: “It is a monstrous idea that the Cottage Hospital should be closed down in favour of large impersonal hospitals – in my view this is tantamount to reducing the individual to the level of a battery hen” (Cheshire Archives, 1971).

Identity-based communities. Identity-based communities include those with a shared identity such as religious beliefs. These were only identified in the case of Mildmay Mission Hospital which had been run as an evangelical Christian hospital since its establishment in 1877. The right of the hospital to retain its Christian ethos and practices was upheld through Clause 61 of the NHS Act 1946 which enabled denominational hospitals to preserve their religious character upon joining the Service. When the hospital faced closure in 1982, Christian individuals and organisations defended the hospital as the “last Christian Evangelical hospital” in England (RLHA, 1983a, n.p.). Closing the hospital was described as a violation of Clause 61, and an attack on religious freedoms.

* 1. *Mobilizing resources*

In each of the nine cases, these different communities shared an interest in keeping the hospital open. Together, they established and supported campaigns against the planned closure of their respective hospital. During these campaigns, various resources were mobilized. Using Edwards and McCarthy’s (2004) typology, we distinguish between moral, cultural, social-organizational, human, and material resources.

Moral resources. Moral resources include legitimacy and sympathetic support for the goals of the campaign. Across the cases examined, we see three main examples of this: (1) public action, (2) support from political representatives; and (3) celebrity endorsement.

First, members of the public (spanning all types of community identified above) wrote letters to the Health Secretary, local health authorities, and Members of Parliament, outlining reasons why they believed their respective hospital should stay open. Communities also signed petitions appealing against the decision to close the hospital. For instance, an estimated 10,000 people signed a petition against the closure of Mildmay, and hundreds more wrote letters to then Health Minister Norman Fowler (RLHA, 1992). In these letters, the hospitals were each defended along the lines of the community’s perceptions, as identified above.

Second, campaigns were often backed by political representatives for the constituencies in which the hospitals were located: Local Council representatives echoed public action, writing letters appealing against the closure; Members of Parliament signed petitions and raised objections in Parliament (e.g. Surrey Archives, 1983).

Third, in the case of Rye Hospital, the campaign received celebrity endorsement from Sir Paul and Linda McCartney who lived near to Rye. Their vocal endorsement was described as a turning point in the campaign: “it caught the imagination of everybody. […] It needed somebody like that behind it.” (Rye, Winchelsea & District Memorial Hospital Ltd, 2021). Paul McCartney described himself as the “ringleader” of the campaign, and recognised the benefits he brought: “It was OK for the local people here, they’ve got a celebrity like me who can give that little but of extra money and can help with the publicity. I feel sorry for the people who haven’t who are just subject to the rules. Of course their hospitals are still closed because they can’t afford to do what we did.” (Moreton, 1995, para.7-8). The involvement of the McCartneys brought extensive media attention to the campaign which achieved national coverage.

Publicity was important in all nine campaigns for attracting moral resources. Campaigners distributed leaflets and flyers to local homes, ‘say no to hospital closure’ posters were displayed in home and shop windows, local newspapers, radio and news stations were contacted to get media coverage of the campaign, and celebrities were recruited for support. For instance, in the case of Tadworth: “Two parents with two terminally sick children appeared on television and ‘tugged’ the heart strings of the nation” (Surrey Archives, 1993, p.67). Through this publicity, closure of the hospitals was framed as bad for patients, bad for hospital staff and doctors, and bad for the relevant health authority.

Cultural resources.In the cases of Tarporley and Odiham, several members of the campaign – including its leaders – had experience of successfully opposing the closure of the hospital. These provided templates of action, and knowledge of how to attract and build public support. For example, facing closure in 1971, supporters of Tarporley formed an Action Committee. This Committee developed a ‘case for retention’ of the hospital, opened a bank account (the ‘hospital fighting fund’) which received donations to further the campaign, met with the Association of Parish Councils to get their backing, encouraged local social groups and clubs to write to the Health Minister in defence of the hospital, and sent a petition around local residents (signed by 12,000 people). When the hospital faced closure again in the 1980s, the Action Committee was re-established, and their campaign followed this rubric like-for-like (Cheshire Archives, 1971-99).

Other forms of specialist knowledge were utilized during these campaigns. For example, finance experts were recruited by campaign leaders to cost different proposals for alternative futures of the hospital (Frymann, 2021).

Social-organizational resources.Various social groups – new and pre-existing – were vital to these campaigns. Campaign members leveraged their existing networks to gain other resources. For instance, in the case of Tadworth, “parents with good contacts and powerful friends exploited them for all they were worth” (Surrey Archives, 1983, p.67).

Organisations connected with the hospitals, such as Leagues of Friends and Hospital Advisory Councils, became “the chief driving force” behind campaigns (RLHA, 1992). In many, this included a mix of organisations and groups which pre-dated the campaigns, and organisations and groups only established once the hospital faced closure. For instance, supporters of Rye, Odiham and Tadworth each established Action Committees – notably called a “Battle Committee” at Tadworth (Surrey Archives, 1983, p.66) – when they faced closure. These comprised hospital staff, former patients (or parents of patients in the case of Tadworth), and volunteers. In each case, these newer groups often collaborated with pre-existing social groups to identify people to target with their appeals. For example, the League of Friends of Tarporley Hospital provided the Tarporley Action Committee with its mailing list, comprised of people who already supported the hospital in some capacity. The League of Friends had itself been established when the hospital faced closure in 1978 as it was thought having a strong League would aid their opposition to closure (Cheshire Archives, 1978). This co-optation of resources helped identify groups of people likely to be adherents of the campaign against the hospital’s closure.

Across each case, Community Health Councils (CHCs) were noted as important defenders of the hospitals and advocates for the communities trying to avoid their closure. Each local health authority had to consult with the relevant CHC about the planned hospital closure. Upon the request of campaigners, CHCs subsequently produced alternative proposals for the retention of these hospitals and possible uses of the facilities. Speaking before the transfer of Tarporley hospital to charitable control, leader of the Parish Council wrote to the Health Minister against plans to abolish CHCs: “Without representation on the Community Health Council and its knowledge of local services it is extremely unlikely that Tarporley Hospital would be in operation today. It is clearly evident in this case that dependence on a remote Health Authority could not have achieved the success of a familiar Community Health Council” (Cheshire Archives, 1980b).

Human resources. In all nine cases, at least one individual was recognized and described as a leader of the campaign. Before the threat of hospital closure, these individuals were already recognized members of the local and/or hospital community, typically with a history of supporting the hospital such as on the hospital board or as a member of the League of Friends. For example, the campaign against the closure of Mildmay was led by Helen Taylor Thompson (Chair of the Board of Trustees), the Tarporley campaign was led by League of Friends Chair Barry Evans, and the Brackley campaign was led by Brackley Mayor George Britchfield. These leaders organised events (e.g. meetings, protests, public talks), coordinated committees (e.g. action groups), communicated the campaign message and updates with the general public (e.g. via press, interviews), liaised with local politicians, and (in the case of Rye) recruited celebrity support. Following the transfer of the hospital out of the NHS, these leaders typically took up leadership roles in the charitable trust under whose control the hospital was. For example, George Britchfield became one of the three founding trustees of the Brackley Hospital Trust.

Material resources.Material resources are both financial and physical (Edwards & McCarthy, 2004). Financial contributions were necessary in each campaign to fund, for example, public awareness initiatives (e.g. through printing leaflets, paying for advertisements). Most of the cases examined have records of establishing an ‘appeal fund’ to which campaign supporters were encouraged to donate. For example, at Tadworth, an ‘Appeal Fund’ was established and “money poured in. Everyone helped: from small boys and their jumblesales to marathon runners and sponsored swimmers” (Surrey Archives, 1983, p.67).

In the case of Mildmay Mission Hospital, funds were raised by selling the Mildmay nursing home. In 1960, the League of Friends of Mildmay had established a convalescent home outside of the NHS as a voluntary organisation using donations received after the hospital had joined the NHS (Wellcome Collection, 1972). In 1984, with Mildmay Mission Hospital facing permanent closure, the Medical Superintendent of Mildmay persuaded the League of Friends to sell the nursing home to raise funds for the hospital’s retention –£300,000[[1]](#footnote-1) was raised in the process. Other funds came from local fundraising, e.g. collection boxes in pubs (Frymann, 2021).

Non-financial physical resources were also mobilized during these campaigns. For instance, access to equipment such as photocopiers and printers (for producing posters and leaflets), and free hire of meeting venues for campaign leadership, were provided by campaign supporters.

* 1. *Negotiation and transfer*

Throughout the campaigns, the objective in each case had been to keep the hospital open. The assumption had been that this would be within the NHS. However, campaigners and local health authorities reached an impasse – it was clear in each case that there was strong public sentiment from a variety of affected communities towards keeping the hospital open, but there remained an insistence from each respective local health authority that they did not have the budgets to afford retention without substantial change(s). Campaign leaders had met with health authorities throughout the campaigns to convey their objections. These communications became negotiations, coming to terms of agreement for alternative means through which these hospitals could keep open. The agreement in each case was that the hospital would transfer from the NHS to a new purposely-established charitable trust.

It is at the point of transfer where these cases substantially differ from one another. In some cases (e.g. Odiham, Rye, Tetbury), the ownership of the entire hospital was transferred to the newly-established trust. In other cases (e.g. Hoylake, Tarporley, Holbeach, Mildmay), initially it was only management of the hospital which transferred on lease agreement (at a peppercorn rate) to the new trusts.

When ownership was transferred, a second campaign was organised to raise the funds needed to purchase the property. For instance: the Odiham Cottage Hospital Redevelopment Trust raised £245,000[[2]](#footnote-2) to purchase Odiham Hospital from the NHS, followed by a further £250,000[[3]](#footnote-3) to refurbish and update the building (Wellcome Collection, 1999); Tetbury residents raised £1 million[[4]](#footnote-4) to ‘buy back’ their hospital from the NHS in 1992 (Videoworks, 2015); and in the case of Rye, £5 million[[5]](#footnote-5) was raised to purchase and refurbish the Hospital, £1 million[[6]](#footnote-6) of which was donated by Sir Paul and Linda McCartney. When interviewed about his contribution, Paul McCartney stated he deliberately did not provide the whole £5 million needed as he did not want to absolve the local community of their sense of responsibility to fund and look after the hospital (Moreton, 1995). These fundraising campaigns built on the support for the preceding ‘save our hospital’ campaigns: they were run by the same people and leadership, appealed to the same individuals, networks, and organisations, and acted as an extension of the original campaign. The campaign frame was similar – still framed around saving the hospital from permanent closure.

When only control was transferred, ownership of the hospital remained with the NHS but management of the hospital shifted from the local health authorities to the newly established charitable trust. However, in several of these instances (e.g. Hoylake), ownership was subsequently also transferred at a later date following a second fundraising campaign.

Spanning both mechanisms of transfer, in several cases, grants came from government to support the transition to charity hospital. For instance, Tadworth received £750,000[[7]](#footnote-7) each year for three years following its transfer, and Tarporley received a grant of £55,000[[8]](#footnote-8) in 1987 towards a rebuild of the hospital.

1. **Discussion**

Community philanthropy is a form of collective civic action through which individuals can collectively mobilize resources in response to recognized social issues (Hwang & Young, 2020). Most research examining community philanthropy has explored (a) organizational forms of community philanthropy (particularly community foundations), and (b) place-based forms of community philanthropy, assuming geography-based definitions of ‘community’. Community philanthropy is a process, not an organizational form. Our analysis examines non-organizational forms of community philanthropy by focusing on the campaigns against hospital closures. These campaigns were all forms of collective civic action through which individuals collectively mobilized resources in response to the planned closure of their hospital which was framed and recognized as a social issue. Resources were mobilized for and around their hospitals – local, nonprofit organisations – and subsequently for the establishment and continued support of a new charitable trust – also local, nonprofit organisations – founded to take on the management and, in some cases, the ownership of the hospital.

Our analysis further highlights the plurality of communities which may interact through and engage in community philanthropy. We identified and distinguished between place-based, need-based, identity-based, and experience-based communities, each with different perceptions of their hospital and reasons for wanting to retain it. This typology supports previous research highlighting the variety of community responses to and attitudes towards hospital closures (Kirouac-Fram, 2010; Barratt et al., 2015; Stewart, 2019), whilst expanding our understanding of the ‘communities’ behind community philanthropy.

These different communities formed a foundation of campaign adherents – those supportive of the goals of each campaign in keeping their respective hospital open (Brauer, 2008). All focused primarily on the individual characteristics of the hospital, rather than its place within the NHS, in contrast to other campaigns against hospital closures which took place from the 1980s onwards (Crane, 2018). What these campaigns shared was a sense of unity: under clear leadership, there was a single coordinated campaign in which multiple communities came together under one clearly defined aim – keep the hospital open. Despite the plurality of communities involved, there were no conflicting efforts – as seen for example in the Booth Hall Hospital case (Barker, 2017) – which may have detracted resources from one another, created confusion through competing objectives, and/or generated fatigue amongst movement adherents receiving requests for support from multiple campaign groups. This clarity of mission and singularity of campaigns helped convert campaign adherents into campaign constituents.

We find that the types of resources mobilized by constituents in each case corresponds with the typology provided by Edwards and McCarthy (2004) – moral, cultural, social-organizational, human, and material. In particular, and to an extent spanning these, we found an importance of social capital, campaign leaders, and effective channels of representation (e.g. CHCs). The ability to mobilize moral resources was essential for convincing local authorities of the need to keep the hospital open and to build a base of campaign adherents and constituents: the hospitals were defended as valuable assets in and for their many affected communities, fulfilling medical, social, religious, and symbolic roles. This framing of the hospitals’ closure as a social problem was successful, building widespread support from across the affected communities (Snow et al., 2019). The ability to mobilize material resources was subsequently essential for taking on the ownership of the hospital, purchasing the property from the NHS with funds raised from campaign constituents. In those cases that immediately took on the ownership of the hospital (either immediately or years later), a second campaign was initiated to raise the funds needed for purchase. These each leveraged the support for the campaign against the hospital closure, and the public awareness and moral support built therein, to seek financial contributions from adherents and constituents of that initial campaign. Material resources – in the form of money – were accessed through patronage (donations) from the various communities that had supported the hospital and the campaign to keep it open.

1. **Conclusions**

In this paper, we have examined the nine hospitals in England which, during the 1980s and 1990s transferred out of the NHS, returning to their pre-NHS status of charity hospitals. Extensive data collection and analysis revealed in each case that transfer came as a last resort to keep the hospital open when the hospital was facing closure. We contribute: (a) examination of the moral, cultural, social-organizational, human, and material resources mobilized through extensive empirical analysis of nine previously unexplored cases; (b) a typology of the different communities involved in these campaigns, including their perceptions of the hospital(s) and motives for joining the campaign(s); and (c) expanded understanding of how community philanthropy can both support established nonprofit organizations *and* establish new nonprofit organizations.

This paper raises questions and concerns about what this means for those communities similarly facing closure of their local hospital but who do not have access to or the ability to mobilize such resources. Resources are not equally distributed across or within communities: one social group may not have equal access to or control over the same types and amounts of resources as another social group; and individual members of any given social group similarly do not have the same resource access and control as one another (Edwards & McCarthy, 2004). Thus, at a time when responsibility for public services is increasingly being handed from the government to private and voluntary sector organisations, communities do not have the same capacity to take on this responsibility and address local issues (Paarlberg & Yoshioka, 2016).

Most of the hospitals we examined are in middle-class, economically wealthy towns and counties. What does this therefore mean for those communities who, for example, lack sufficient funds, clear campaign leadership, or vocal support from political representatives and local celebrities? What about hospitals that have faced or face closure since the abolition of CHCs in 2003? CHCs were replaced with local involvement networks, but these do not have the same powers and resources that CHCs were afforded. Given the influential role of CHCs in the nine cases we examined, are subsequent campaigns disadvantaged by the lack of such powerful representation? These questions are largely speculative. In the absence of a list of all hospitals that have faced closure at one time or another, and their postcodes, we are unable to link them to information on measures of prosperity or disadvantage.

Regardless, the findings of this paper indicate it would be more challenging for communities to oppose the closure of their hospital, or to take on the ownership and/or control of the hospital, if they lack access to and the ability to mobilize each of the following: moral resources (support from public, political representatives, and celebrities); cultural resources (experience of running social campaigns); social-organizational resources (influential networks and social groups such as Leagues of Friends and patient representative bodies); human resources (clear campaign leadership); and material resources (primarily financial).

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1. £1.2 million in 2023 prices. [↑](#footnote-ref-1)
2. £540,000 in 2023 prices. [↑](#footnote-ref-2)
3. £550,000 in 2023 prices. [↑](#footnote-ref-3)
4. £2.6 million in 2023 prices. [↑](#footnote-ref-4)
5. £12.3 million in 2023 prices. [↑](#footnote-ref-5)
6. £2.5 million in 2023 prices [↑](#footnote-ref-6)
7. £3 million in 2023 prices. [↑](#footnote-ref-7)
8. £200,000 in 2023 prices. [↑](#footnote-ref-8)