breaches of the convention, monitor and promote compliance with the convention, scrutinise children's access to complaints procedures, develop models for the use of child impact statements on national and local government policy, and to report annually to parliament on the state of children's rights. Such work would need to be informed by the views and experiences of children and young people themselves.

We need an office of children's rights commissioner, together with a clear government strategy for children and a minister for children within the cabinet office.⁷ These initiatives would mean that the next report to the United Nations committee, in 1999, could be approached confident in the knowledge that the principles and standards in the convention had been given serious consideration and that respect and care for children had been placed at the centre of the political agenda. Meanwhile, for those who work with children in the

health service, there is no escaping the fact that the responsibility of ensuring the rights of children as established in the convention rests with us.

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1 *The UK's first report to the UN Committee on the Rights of the Child*. London: HMSO, 1994.

2 Lansdown G, Newell P. *UK agenda for children*. London: CRDU, 1994.

3 Committee on the Rights of the Child. *Concluding observations of the Committee on the Rights of the Child: United Kingdom of Great Britain and Northern Ireland*. Geneva: United Nations, 1995. (CRC/C/15/Add.34.)

4 *Making the convention work for children: explaining the history and structure of the UN Convention on the Rights of the Child and its application in the UK*. London: Children's Rights Office, 1995.

5 Alderson P, Montgomery J. *Health care choices: making decisions with children*. London: Institute for Public Policy Research, 1996.

6 *Child health rights: implementing the UN Convention on the Rights of the Child, a practitioner's guide*. London: British Association for Community Child Health, 1995. (Obtainable from British Paediatric Association, London NW1 4LB.)

7 Newell P, Hodgkin R. *Effective government structures for children: report of a Gulbenkian Foundation inquiry*. London: Calouste Gulbenkian Foundation, 1996.

Falling back on charity

Our rights to health care can only be met if we honour our obligations as tax payers

Christmas is the season of charitable enterprises. Last month, the London School of Economics commemorated the life and work of Professor Brian Abel-Smith, the distinguished British health economics and policy analyst. It is just over 40 years since he published his history, *The Hospitals*, in which he explored the mixture of professional interests and charitable sentiments that inspired the growth of the voluntary hospital movement in Britain.¹

Abel-Smith was critical of the manner in which the largely unregulated exercise of clinical discretion and undirected benevolence sometimes distorted the ordering of priorities in the development of health care before 1946. At the same time, he was in no doubt that charitable endeavour and medical professionalism had always been forces for good in the enhancement of human welfare.

However, *The Hospitals* also stands out as a celebration of the virtues of collective benevolence in the public sector of health care. It is a work that describes, in lucid and engaging prose, the reasons why it was necessary to create a national health service in 1946 and why it took the form it did. Abel-Smith also shows why the voluntary hospital movement, despite its laudable achievements, had ceased to be financially viable after the second world war.

In two respects, at least, we compare unfavourably with our Victorian forebears. Firstly, in the supposed heyday of rugged individualism, successive governments found the money and the will to launch a major building programme of public hospitals when the need for them became apparent. They responded to this challenge in a spirit of compassionate pragmatism rather than dogmatic attachment to abstract economic and managerial theories.

Secondly, in defiance of the principles of less eligibility, many of the medical staff of the poor law infirmaries gave the benefit of the doubt to patients whose medical needs were less urgent than their need for good food, warmth, and social care. Countless children of the poor, nursing mothers, and infirm elderly were kept on the wards as semiconvalescent cases in order to build up their health and strength before their discharge.

Of course, we can no longer afford to use hospitals as centres of social care for the frail elderly and chronic sick. Nevertheless, it remains the case that—despite all the vagaries of social reform from the Seebohm report² to the creation of internal markets—there is still nowhere for many of these patients to go after hospital discharge if they cannot afford to buy the care they need. As a result, our local authority social service departments are being transformed into de facto destitution authorities of last resort and minimal resource.

The Hospitals covers a subject and a period in which the voluntary hospitals movement came to epitomise all that was best in the traditions of charity. But from the 1870s onwards our governments came to recognise the limitations of both charity and private markets in health care. Their bold initiatives in the public sector did not spring out of a moral vacuum; they were as characteristic of the political culture of Victorian society as were laissez faire and commercial enterprise. It was a time, unlike our own, in which public servants were looked on as useful members of the community rather than as public enemies. It was also a time in which doctors exercised perhaps too much professional discretion, but who is to say that such a state of affairs was less preferable than one in which they exercise hardly any at all?

Nineteenth century medical charity was dispensed through the exercise of lay and professional discretion. The provision of health care today is, or ought to be, grounded on the bedrock of reciprocal civil rights and obligations. However, as voters, our rights to health care can be met only if we honour our reciprocal obligations as tax payers. If we fail to do so, more and more categories of patients will find that their rights to free care are diminished. As the mainsprings of public benevolence run dry we will, once again, become increasingly dependent on the idiosyncrasies of charitable discretion.

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1 Abel-Smith B. *The Hospitals 1800-1948*. London: Heinemann, 1964.

2 Seebohm F. *Report of the committee on local authority and allied personal social services*. London: HMSO, 1968.