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Social protection in Britain 1900-1950 and welfare state development: the case of health insurance

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Introduction

In historical debates on the origins of European welfare states, the name of William Beveridge and his Report¹ of 1942 is frequently invoked. This report received much publicity, both at the time and since; it is widely regarded as the blueprint for the post-war British welfare state. Although Beveridge's proposals, in retrospect, appear less radical than one might suppose (representing the extension, consolidation and rationalisation of earlier social insurance schemes), in one respect the British post-1945 welfare state initiated a complete departure from established practice. Unlike France, Germany, the Netherlands and Belgium, where social insurance was consolidated after the Second World War, the British government abandoned the UK health insurance scheme (created in 1911) and opted instead for a tax-funded National Health Service (NHS), free for all citizens in need. This paper, therefore, will not examine the spread of social insurance as a vehicle for social improvement and modernity, but its *failure* and eventual demise. This is not a history of success.

The contrasting fate of UK health insurance when compared to its continental counterparts can be ascribed to profound differences between British schemes of social insurance and those found in other European welfare states. Behind the same label (social insurance) lurked very varied systems. First and foremost, reflecting the liberal traditions dominating British social policy, social insurance benefits were never designed to offer more than a minimal income: to act as protection against destitution. In contrast to French and German schemes, Britain's state support has always been based on flat-rate (not earnings-related) contributions and benefits and has always contained a state contribution. This creates a second major difference. In Britain, as the following account will show, public subsidies endowed central government with extensive regulatory powers over benefit administration – in the name of safeguarding the interests of the taxpayer. Here, the central state exercised much greater

authority over local funds than it did in France, Germany or Belgium, where contributory income was higher, public tax subsidies either absent or locally located and central government less able (and, until recently, less inclined) to control fund activities². In Britain, in contrast, a liberal state belies its name. While in Europe (notably Germany, France, the Netherlands, Austria and Belgium), the governance of social insurance has long embodied varied forms of social representation and social democracy, in Britain this aspect diminished steadily and, following the Beveridge Report, disappeared completely.

In some respects this contrast seems perverse: from the very inception of social insurance, a state with a strong reputation for liberalism acted in a far more authoritarian manner than some ostensibly more authoritarian states did. However, the object of a liberal British version of social insurance (protection against destitution at minimal public cost) rests on tenets of individual self reliance and on the virtues of market competition and choice. Hence, on the one hand, the local 'approved societies' that ran the UK health insurance scheme competed for members in a manner not found elsewhere in Continental Europe. On the other, central regulations endowed processes of central audit with extensive powers; the British version of social insurance was designed from the start to limit the demands of the poor on the taxpayer. Throughout the nineteenth century, a punitive poor law had been the only official source of help for the destitute; hard labour and loss of civil rights for the recipient paupers had reinforced the message that the poor were supposed to take care of themselves and not to rely on others for their well-being. By the end of that century, however, the whole financial structure of the poor law was breaking down: in central urban areas, demand for help outstripped the ability of local authorities to pay for it and this situation stimulated demand for reform. Hence the appeal of social insurance for the reforming party of central government (and particularly for the Treasury) lay in the way that it promised to limit demands made by the poor on the public purse by forcing working people, through their contributions, to save against hard times.

The reasons why public finance was (and remains) so influential in shaping British social protection are largely embedded in Britain's imperial past: in the legacy of protecting the pound sterling as a major global trading currency and the role played by the Treasury as guardian of that legacy. While the genesis of social insurance modified this attitude, it did not remove it. Hence even Beveridge's modest recommendation (1942) that flat-rate benefits should be fixed at subsistence level was never implemented. Britain's Treasury has retained

ever-tighter control over the administration of all its social insurance schemes. The history of British social protection is one of liberalism, more liberalism and yet more liberalism.

The paper that follows examines this legacy in action. Rather than attempt a description of all forms of British social insurance before World War 2, the focus will be (as indicated above) on the operation of the UK health insurance scheme alone. The choice of health insurance allows a more precise analysis of the problems encountered by a scheme that, although derived from long-established systems of mutual aid, became distorted by the exigencies of market competition, regulatory complexity and an excess of central financial control. Further, this sector facilitates comparative perspectives as other European countries also promoted health insurance schemes during the early twentieth century. The other major branch of social insurance in Britain at this time – unemployment insurance – has far fewer comparators in the pre-1939 years. Finally, as European systems of social insurance are currently being pushed towards a more market-oriented ethos, the problems encountered by British National Health Insurance between the wars serve as a timely reminder that competition and so-called consumer choice do not automatically offer sound foundations on which social protection can build.

To explore this agenda, the first section of this paper will outline the systems of mutuality that served as the basis for social insurance in Britain. The second will briefly describe the operation of National Health Insurance (NHI), stressing the strong control exercised by central government over its operation and its impact on mutual aid societies. The third section will demonstrate the political consequences for the scheme: how close associations between constructions of certifiable sickness and labour market change emerged in the inter-war years and the damage done to popular attitudes towards NHI. Specific reference will be made first, to heavy industry and second, to gender. Access to health care and perceptions of sickness were shaped by government officials who determined what forms of illness were viewed as legitimate sources for claims to benefit. This explains why NHI was abandoned as the basis for UK health care in 1945. The final section will place Britain's experience in its wider European, comparative context and draw some conclusions.

Origins of British social insurance

The creation of Britain's first scheme of social insurance in 1911 has excited widespread historical attention. Its antecedents are perhaps less well known. Voluntary membership of friendly societies expanded steadily throughout the nineteenth century as a consequence both of working class revulsion against the poor law and growing official encouragement, including legislative protection of the funds. Hence mutual aid in Britain was highly developed: by 1892, over 7 million policies held by members of friendly societies were in existence³. Here, the word 'policy' is used advisedly: the object of voluntary registration under the Friendly Society Acts was not simply to protect society funds against the risk of embezzlement, but also to guarantee actuarial solvency. In this respect, the societies bore some resemblance to insurance companies: the first society actuary (who subsequently became the first Government Actuary in 1911) worked for the Manchester Unity of Oddfellows (the largest friendly society) with the task of guaranteeing the Manchester Unity's solvency. Membership of non-registered societies was also buoyant; nearly 50% of society members were in non-registered funds at the turn of the century. Aside from the myriad of local societies whose organisation remained highly informal, trade union benefit schemes were prominent among these unregistered systems. Unlike France, but like Germany, trade unions ran mutual aid funds in Britain⁴. These offered benefits that registered friendly societies were forbidden to offer by law: strike and lock out pay, unemployment benefits. By 1908, 1.84 million union members could claim protection against unemployment from their union. While the provision of such 'friendly benefits' was officially well regarded, their close association with strike action was not⁵. Union branches financed all activities from the same fund and official efforts to introduce new and more sophisticated financial controls were, until 1911, successfully resisted.

A major distinguishing feature of the mutual aid movement in nineteenth century Britain was its independence: both friendly society and trade union finances were reliant on membership subscriptions alone. The vast majority of these funds were run and managed by the members themselves. Outside the railway companies, one or two gas companies and coal mines in the north-east coalfield, employers did not run mutual benefit schemes for their workers. Friendly societies recruited overwhelmingly among artisanal and skilled blue-collar workers – carpenters, stonemasons, miners, ironfounders, engineers, plumbers, printing trades and skilled textile workers. A few (such as the Catholic Benefit Society and notably the Orange Lodges in Northern Ireland) were based on religious orientation. Friendly societies, with their monthly meetings and democratic systems of management (through members' monthly

meetings at the local pub) dominated the industrial north of the country. Here the ‘affiliated orders’ – national networks of local branches (or ‘lodges’) – such as the Ancient Order of Foresters, the aforementioned Manchester Unity, the Loyal Order of Ancient Shepherds and the International Order of Rechabites (this last being a temperance society) - were powerful not only in the UK, but also in British dominions overseas such as Canada and Australia. These affiliated orders, ‘a state within a state’ according to Sidney Webb, created formal rules concerning benefit rates and contributions and oversaw the activities of their component lodges or branches, acting as a type of bank (brokering loans from a branch in surplus to help a branch in difficulties). In this respect, they differed little from the Friendly Society of Ironfounders and the Amalgamated Society of Engineers, founded in 1834 and 1852 respectively, which also offered similar benefits but were essentially trade unions as they also offered help to members in dispute with their employer and only recruited within specific trades.

Hence the divisions between the friendly society movement and the trade union movement were barely apparent before 1911. Both sustained the same principles by remarkably similar means: both protected the dignity of respectable industrial workers from the threat of any association with poor relief and pauperism. Both encouraged independence and self discipline. Rights to benefit were subject to nationally agreed rules. In principle, high contributions from relatively well-paid workers funded a range of benefits (help for the sick, injured, aged and, for trade unions, the unemployed); rights varied by area (or industrial sector) and by length of membership. In trade unions, members were supported for refusing work offered on non-union terms: that failed to pay the recognised union rate, for example, or in firms employing too many apprentices. Equally, trade unionists were fined for accepting such work or for working alongside non-members when there were union men ‘on the books’⁶. Fines held the same status as contribution arrears: union support was denied until they were paid. Hence union benefit schemes regulated work practices in skilled trades, where mass strike action was consequently rare. In both unions and friendly societies, benefit schemes also sustained membership: seniority frequently translated into higher benefit rates or extended rights. In political terms, while trade union provision of friendly benefits was officially well regarded⁷, their close association with trade dispute was not. The policy debate about unemployment protection, therefore, was partly shaped by state aims to reform trade union systems of classification, to distinguish the unemployed, the retired and the sick from

those on strike - provoking dissent within the union movement and opposition to state intervention in the labour market as a result.⁸

The strategy underpinning the reforms introduced by Liberal governments in Britain, specifically the National Insurance Act (1911), was designed to spread the benefits of society membership to a wider section of the working class while containing possible 'abuses' of the new schemes. The 1911 Act was divided into two parts: the first introducing a universal scheme of health insurance (discussed in the following section) and the second creating a limited, centralised unemployment insurance scheme. Trade unions and friendly societies were admitted as administrative agencies under both parts of the Act. However, registration as an administrative agency carried its penalties, namely stricter surveillance by central government over society systems of benefit administration. Official surveillance ensured that only applicants of good character and sound working habits were to receive state benefits. The object of policy was not benevolence, but to remove the inefficient, the sickly, the incapable in order to promote industrial prosperity and economic growth. Regulations covering access to benefit, based on actuarial calculation, sought to separate the regular contributor from the rest (the 'morality of mathematics' according to the young Winston Churchill). An established contributory record and the limitation of benefit duration meant that support was only available to short-term claimants who had been in regular employment. Rules disqualified claimants whose unemployment was due to dismissal for misconduct or to industrial dispute and the state encouraged established society practices of 'friendly' sick visiting to discourage 'malingering' at public expense.

The birth of social insurance in the UK formed part of a wider strategy to revive and restore Britain's commercial pre-eminence by creating a more efficient labour market. The problem of poverty was located in the context of industrial and national efficiency (and its consequences for British commercial and imperial pre-eminence) on the one hand – and in the collapse of local poor law finances on the other. Unlike other European countries, the threat posed by the poor was not political, but economic. The solution lay in rationalising the distribution of work, to remove the dross and to protect regular workers. As for the rest of the rejected poor, policy remained hazy about their fate: punitive poor law treatment was tightened up in 1911, in the wake of the passage of this new legislation.

National Health Insurance in Britain: its scope and operation

The National Health Insurance (NHI) scheme, the brainchild of Lloyd George, lasted from 1912 until 1948, combining what are now classified as social security benefits (sickness and disability benefit) with basic medical care. In return for a tri-partite contribution from worker, employer and the state, it offered access to a doctor (General Practitioner) plus a flat-rate cash benefit. The scheme covered all workers with annual earnings below a specified annual amount – but not their dependants and families. After 26 weeks, sickness benefit was transformed into disability benefit, at half the previous rate: a change designed to discourage ‘malingering’ by forcing all but the most desperate to return to work. Those covered by the law expanded from 11.5 million (1912) to 20.26 million (out of a total population of 47.5 million) by 1938⁹, including about 640,000 voluntary contributors¹⁰. Rising numbers reflect population growth, the raising of the earnings ceiling to £250 p.a. in 1920 and the larger number of women covered by the scheme – which stood at 6.11 million by 1938.¹¹

The scheme was administered by centrally registered ‘approved societies’ which included industrial insurance companies alongside the friendly societies and some trade unions. Industrial insurance companies managed to become administrative agencies because friendly societies had never recruited women and, under the 1911 Act, large numbers of low-paid women workers were now obliged to register under the health scheme. Approved societies administered benefits, paid the ‘panel’ doctors and local dispensaries through local insurance committees and supervised daily operations. Legislation guaranteed that approved societies were non-profit making. Lloyd George introduced the scheme in imitation of Germany’s Bismarckean counterpart. As in Germany, NHI was originally designed in 1911 to promote social democracy, to allow society members to manage their funds – thereby extending established friendly practices of mutual protection at a time when only 60% of the adult male (and none of the adult female) population had the vote.

However, quite unlike its German counterpart, NHI operated on a competitive basis. Contributors were as free to choose their society as societies were to reject them; the scheme was designed to stimulate competition. While all societies were compelled to provide statutory minimum cover, the more successful ones could, with official approval, attract new recruits by using the profits accruing under NHI to fund additional benefits (usually ophthalmic and dental care, specialist hospital services or extra cash payments). The

possibility of using extra benefits to attract new members encouraged careful administration to safeguard society balances. Better benefits attracted new members, helped business to expand and offered the prospect of ‘cherry picking’ (only admitting the youngest and healthiest applicants who would make fewest claims on society funds). Even so, societies tended to help claimants because callous treatment could alienate new recruits. Participation in the public scheme helped promote private interest. Societies sought, with official endorsement, to encourage members to purchase a private policy to supplement the public one; it is through such extensions in private business that the more commercial organisations (the industrial insurance companies) secured their profits.

Here, the histories of friendly societies and industrial insurance companies diverge. Voluntary friendly society membership held more or less constant over the period in question (at around 6 million policies). Membership of commercial insurance societies – and voluntary life insurance - grew at an unprecedented rate; commercial insurance agents toured their allocated districts house to house, knocking on doors, befriending the housewife and recruiting new lives before the trade unions or traditional friendly societies had a chance. By 1939, an average of 2.5 life policies existed for every UK citizen and four out of five policies were held by one of 14 major industrial insurance companies. Of these, the Prudential was easily the largest, running four approved societies with a combined membership of 4.3 million and holding 29 million private policies¹². As approved society profits could only be spent on extra medical benefits, commercial companies like the Prudential used NHI activities as a loss leader to attract private business, which raised the commercial insurance agent’s commission. ‘... It has been frequently suggested to us,’ a committee commented in 1914, ‘that the agent of industrial insurance societies is urged to an attitude of undue leniency [towards claims for NHI health benefits] with those with whom it is necessary he should live on amicable terms, if he is successfully to carry out his ordinary business.’¹³ Friendly societies claimed that commercial companies gave state sickness benefit to all comers: societies that policed their members lost them. While commercial organisations evidently gave claimants a kinder reception than that offered to the unemployed by the public employment exchanges, this association between private profit and public benefits provoked extensive criticisms, endorsed in the Beveridge Report, and fostered the demise of the health insurance scheme in the longer term.

However, a notable feature of British health insurance – one that distinguishes it clearly from its Continental counterparts – lies in the tight controls exercised by central government over its finances and hence its operation. All contributory income under the scheme ended up in the coffers of the Ministry of Health. Employers purchased official stamps from the General Post Office and stuck them weekly in the NHI book of each employee (deducting the worker's contribution from wages). When full, the book was returned to the worker's approved society; the society returned it to the ministry as proof of income – which, in turn, credited the society's account held in Whitehall. Actual cash was transferred to the society retrospectively, on receipt of six-monthly audited accounts. The government audit department inspected the books; any 'improper' society payments – which did not conform to central regulations or the society rules – were not reimbursed. Every five years, the Government Actuary, who was charged with ensuring the financial viability of each society, used these audited accounts to predict future profitability. These valuations determined the division of profit between additional medical benefits, centrally held 'contingency funds' (insurance against future losses) and investments, both by the society itself and by central government on its behalf. Contrary to historical opinion¹⁴, the system made it impossible for profits derived from the official health insurance scheme to be transferred to the pockets of society officials or company shareholders or anyone else.

As the state contribution (one third of benefit paid) was added on when reimbursement of benefits was paid back to the societies, central government had a vested interest in restricting access to the scheme by the sick. This was particularly true in the inter-war years when tight public expenditure constraints were in operation. Following major reviews of state expenditure, the government contribution to NHI was formally cut back on three occasions – twice in 1925 and again in 1931¹⁵. These cuts were never restored. Lloyd George's boast in the House of Commons, that the British scheme was superior to its German counterpart because its Exchequer subsidy would allow it to offer more, proved completely untrue. In the name of safeguarding the public accounts, the Government Actuary and his acolytes converted society profits into savings to the Treasury rather than better health benefits for the contributor.

This prevented health care from expanding to cover the families of the insured and strangled social democracy at birth. Approved friendly societies swiftly discovered that, as far as NHI went, their autonomy was heavily circumscribed. 'Our [branch] secretaries are simply being

converted into state officials...’ a Manchester Unity of Oddfellows representative claimed in 1914, ‘It is said that the funds have been administered by self-governing societies, but then we know as a matter of fact that they are not self-governing.’¹⁶ In the words of the National Association of Trade Union Approved Societies (NATUAS) in 1925, ‘membership control is a sham and a farce.’¹⁷ Neither members nor their elected representatives had much say in the running of society affairs and, in the long run, member participation (the hallmark of friendly society practice) dwindled away. By the 1940s, Mass Observation found the friendly societies in a poor state, with low (or no) participation at meetings, an aging membership and few new recruits. ‘It used to be fun in the good old days when we had a sheep’s head supper here and perhaps a hundred of us together’ one old member observed following a meeting where only a dozen 60-70 year olds had attended. ‘The Government’s cut out all that friendliness’ commented another. ‘Meetings? Cor, no! We don’t have none of them now.’¹⁸

Nor was NHI popular with the medical profession. For qualified GPs, the friendly society movement had always been a mean employer. Remuneration was minimal (doctors were paid a per capita fee and were expected to meet the costs of any prescribed medication themselves) and such work was commonly regarded as a stepping stone on the way to the acquisition of a more lucrative practice involving middle-class patients (not included under NHI) who paid realistic medical fees. The advent of the NHI scheme witnessed renewed attempts by the British Medical Association (BMA) to win higher pay from the approved societies. This eventually was granted in 1924, with some support from the Ministry of Health. However, this award was an isolated case; as the prolonged industrial recession raised government anxieties about approved society solvency, so civil servants were increasingly disinclined to extend the range of NHI medical treatments or make approved societies raise medical salaries. At the outbreak of war in 1939, official attitudes changed abruptly. Medical salaries were standardised and rates of pay were raised; hospitals were re-equipped and new personnel recruited. For the BMA, this seemed like Christmas and the association was converted instantly to the merits of a permanent nationally funded medical service – as witnessed in their published report of 1941. However, prior to the war emergency, senior civil servants in the Ministry of Health used society opposition to any increase in their costs as an excuse to block BMA demands as well as public demand for extended health cover. The societies offered a convenient disguise for proponents of central control.

This lack of society autonomy marks one feature distinguishing British health insurance from its German counterpart. In his evidence to a departmental committee in February 1914, Sydney Webb stressed the superior health care available to German contributors. German insurance offered dental care, spectacles and a full range of appliances (elastic stockings, trusses, specialist footwear, artificial limbs) that were excluded under the UK regulations (other than as additional benefits). There were fewer patients per doctor than in Britain, better and more evenly distributed hospitals and German insurance funds allowed patients and doctors access to full diagnostic facilities and hospital care¹⁹. A cautionary note should be added, however. In the UK, publicly funded health services, run by local government, operated alongside the NHI scheme. These local health services were charged with administering legislation on public health. Hence local authority health departments ran hospitals and clinics for specified infectious diseases, maternity and infant welfare schemes, employed health visitors and district nurses. Local education departments were charged with provision of school medical services. These local responsibilities expanded during the inter-war years, notably after the Local Government Act (1929) transferred responsibilities for local poor law institutions (mainly for geriatric and mental care patients) to local government. In more prosperous parts of the country, notably London and Oxford, this transfer enabled wealthier local authorities to rationalise local hospital services, to provide care to all residents. Opinion within the Ministry of Health therefore remained divided over whether health insurance or local health departments should be charged with future development of health care in the 1920s. During the following decade, opinion swung in favour of the public sector, determining the future shape of the NHS. In this way, the commercial orientation of British health insurance necessarily divorced it completely from local authority activities in the sphere of public health, allowing the two to emerge as rivals rather than in collaboration (as in other European countries at this time).

This description of administrative practice offers a framework for analysing the ways in which the British health insurance scheme shaped an official understanding of sickness among the working population – and to this agenda we now turn.

Health Insurance and its Patients

NHI in Britain was not located politically within the realm of public health, but within that of social insurance. The National Insurance Act (1911) had been designed less to cure disease

than to prevent pauperism. Contributory insurance offset the burden imposed by poor relief on local ratepayers. NHI offered the sick basic medical treatment and time off work to recover, ostensibly preventing the development of chronic complaints that might force permanent withdrawal from the labour market, transforming those temporarily unable to work (and their families) into paupers.

The attachment of NHI benefits to labour market status had marked implications for the construction of sickness that emerged within its remit. First, industrial restructuring and fluctuating labour demand during this years 1919-39 influenced the type of complaint brought to the attention of the approved societies. Here attention is drawn to the nature of the inter-war recession: its adverse impact on heavy industries that virtually manufactured physical problems, the propensity of employers when discharging labour to prefer young and fit over older, potentially less productive workmen. Second, the administration of health insurance overlapped with other benefits and allowances available to workers whose health could be less than perfect. This refers not only to the unemployment insurance scheme (introduced in restricted form in 1911 and extended in 1920) but also to workmen's compensation for industrial accidents, paid for by employers, and to war pensions given to 1.25 million disabled ex-servicemen after 1918. During the inter-war years, as public expenditure constraints tightened and employers sought to cut costs, the financial liability of all schemes was under constant review. This provoked a considerable degree of 'claimant shuffling' as separate agencies sought to minimise their liabilities: an expensive, time-consuming and ultimately pointless process that Beveridge subsequently sought to eliminate by uniting all state benefits under a single agency. As noted above, competition between societies (and the desire of doctors to extend their patient lists) fostered a degree of leniency towards NHI claimants in contrast to the reception some of them found at the labour exchanges. Health insurance tended to become the agency of last resort when all else failed: health benefits were lower than unemployment benefits, war pensions and workmen's compensation. However, the member with a private policy to complement the public one found (s)he could get more money with less fuss from the approved society than was available under other schemes.

Two case studies illustrate the point. First, the minutes of the Tunbridge Wells Equitable Approved Society [TWEAS] for 23 October 1915²⁰ tell of a member who injures his knee at work, continues at work before the deterioration in his condition forces him to quit for four

weeks, successfully claiming compensation from his employer. One month following his return to work, the condition revives and he is laid off with chronic rheumatoid arthritis. He claims on the TWEAS and the case is disputed: the TWEAS doctor said the condition was due to the accident, the employer says it is simply rheumatism. An independent doctor called to mediate identifies the condition and agrees that the accident is the probable cause but adds that rheumatoid arthritis ‘owing to the very bad state of his teeth, might have developed sooner or later, even if the accident had not happened.’ The employer succeeds in repudiating responsibility. In the second, at the height of the Slump, a female pub cleaner applies to the Unemployment Assistance Board²¹ following the loss of her job. Although she suffers from headaches, she has been in regular employment for a number of years. Her case is referred to the UAB doctor, who refers her to her approved society, noting that, in view of the appalling state of her teeth, he is amazed she only suffers from headaches as she evidently has incipient blood poisoning.

These two cases illustrate various issues. First, the lack of dental care under NHI had a significant impact on the incidence of other medical complaints, including those of the digestive tract as well as the conditions referred to above. By the late 1930s, around 85% of approved societies offered additional benefits, frequently including dental care. However, additional treatments required the patient to meet a proportion of the cost; as dentistry was unpleasant and involved the member in extra expense, the benefit was under-subscribed. Some preferred to have all their teeth extracted at once, rather than persist with the more expensive alternative of long-term maintenance. Second, in both cases, the claimant evidently preferred work to any form of claim and any form of claim over NHI benefit – illustrating the point made above that NHI was the claim of last resort. Insurance companies (supporting employers in compensation cases) and the Ministry of Pensions employed medical expertise beyond the purse of approved societies. Hence the personal physical attributes of the claimant (impeding full recovery) gained greater significance than potential causes of industrial accident or disease in determining liability. This means that very little was known, then or now, about the prevalence of specific industrial diseases – or accident rates – in Britain as the institutional provenance of the statistics is so unreliable. Finally, the cases both illustrate the narrow dividing line between ostensible health and sickness: how underlying conditions could develop into debilitating illness and how poor health maintenance contributed to such developments over time.

The Ministry of Health, ultimately responsible for approved society solvency, did not take kindly to the way NHI was used as a general dumping ground for all comers. The issue was possibly less the comparative generosity of the societies themselves than the apparent readiness of panel doctors to issue certificates to all comers in order to sustain – or extend – their patient lists²². ‘We never saw toothache, headache or earache [on a medical certificate] until the National Insurance Act commenced operations’ grumbled an approved friendly society representative to an official enquiry in 1914²³. At its inception, NHI evidently extended definitions of sickness to cover a wider range of complaints than had not traditionally been accepted by the friendly societies. However, the inter-war recession changed all that. Unemployment rose, contributory income slumped and claims soared, threatening society solvency. Between 1921 and 1927, sickness benefit expenditure rose by 50% for women and 33 % for men²⁴ and these figures continued to mount in the ensuing years.

Industrial recession and changing health experience

Rising levels of sickness can largely be explained by heavy industries shedding labour in the depression. Older, less productive (and less healthy) workers were the first to be laid off. In the context of a tightening labour market, these groups had the most difficulty in securing another job. Under such circumstances, a relatively minor physical impairment quickly became translated into a major medical complaint – particularly when the sufferer found his chances of work ruined repeatedly because of it. Add to this the psychological strain and poverty associated with unemployment and it seems likely that physical problems among the unemployed worsened over time: high unemployment both revealed and caused sickness. However, there is ample evidence to show that other workers with similar problems laboured on regardless, simply because of their jobs were at risk if they took time off to recover. Hence industrial disputes impacted on numbers claiming health benefit. During the six-month coal stoppage of 1926, miners’ claims to sickness benefits rose by over 60%²⁵. This was not an isolated case. ‘It cannot be doubted’ commented the Welsh Board of Health following the miners’ strike of 1931 ‘that many men capable of work were claiming sickness benefit simply because the pits were idle.’ In this instance, miners’ claims to NHI had risen by a factor of three over a two-month period²⁶. Men on strike could not claim unemployment benefit; the poor health endemic among pit workers, however, made access to medical certification almost a routine alternative. Mining topped the list of industries generating the greatest

number of claims to NHI for lung, eye and chest problems, a range of presumably arthritic complaints ('beat' knee or elbow) as well as the inevitable injuries.

As the Unemployment Fund went into seemingly permanent deficit, the Ministry of Labour – under pressure from the Treasury – 'tightened up' on access to benefits under its control. As access to unemployment benefit was restricted, so applications for health benefits rose. 'I do not expect the Ministry of Labour to listen to reason', the Government Actuary commented acridly as the 1930s Slump took its toll. 'but I am sure that the harsh conditions of Unemployment Insurance are responsible for a considerable part of the disablement benefits we are paying and, what is worse, for the destruction of the will to work which is producing so many human derelicts.'²⁷ These developments prompted the Ministry of Health to police claims as well, transforming definitions of sickness in the process. 'Incapable of following his usual occupation' – the traditional definition used by friendly societies – was replaced by incapacity for any work at all. Regional Medical Officers (RMOs) were employed to double check the health of long-term claimants and societies were urged to check up on doctors who issued too many certificates²⁸. The convalescent and the partially incapacitated were to be excluded; the claims of all in less than perfect health – the bronchitic, the rheumatic, the neurotic – were thrown into question. The TUC argued that pressure on claimants to 'declare off' the funds led to premature resumption of work; this invariably resulted in the return of the original condition and permanent invalidity²⁹. Recommendations favoured by RMOs, that the claimant was capable of 'light work', were unrealistic in areas where no such employment existed. Official pressure however, was very unevenly applied. In more prosperous areas, where society solvency was not a problem, the ministry's advice went unheeded. In contrast, the Scottish Department of Health operated a draconian regime, dictating the maximum duration of diseases like 'flu and anaemia, post-operative recovery periods for surgery on hernia or appendix – and suing doctors who failed to follow official advice³⁰. In general, in the areas of high unemployment in heavy industries located in the north and west of Britain, a more vulnerable population received poorer medical care. The uneven distribution of medical care, noted at the birth of NHI, did not disappear and has plagued the NHS ever since.

NHI and women's health

NHI only covered the employed workforce; as a very large proportion gave up work on marriage, women covered by health insurance were mostly young and single. Most continuing to work after marriage tended to be from the poorest working class households: employed in industries like pottery-making, textiles, the clothing trades or in domestic service – a classification covering various low paid jobs in catering, cleaning, pub and hotel work as well as parlour maids and cooks. Analysis of the high rates of female sickness experienced under NHI has to be placed in the context of the comparative poverty of households containing married women workers and the tactics employed by the Ministry of Labour from 1921 to exclude women from unemployment benefit. In that year, a means test disqualified discretionary claims from anyone living in a household with someone in work: a regulation affecting daughters and wives and aimed specifically at ex-munitions workers. In 1922, employment exchanges were instructed to offer any female claimant a job in domestic service. This placed her in a double bind: if she refused the job, her claim was disallowed because she had rejected work she was physically capable of doing. If she accepted it, she left the unemployment scheme because domestic service was not an ‘insured trade’. Excluded from unemployment benefit, women’s rates of claim to NHI rose faster than those of men. By the mid-1930s, domestic service was running second only to coal mining as the most common occupation among long-term claimants to health benefits, reflecting the ill effects of low pay and physical labour as well as administrative discrepancies in the treatment of the unemployed.

From the start, high rates of female claim were a cause for official concern. An official enquiry, set up one year after the scheme started, investigated why sickness experience was higher than had originally been anticipated. As early estimates had been drawn from the experience of friendly societies – and as friendly societies had largely excluded women – interest focused on the reasons why female claims in 1913 were about 25% above the male rate. Apart from explanations concerning benefit-induced sickness³¹, evidence indicated the prevalence of throat and lung problems (particularly among textile workers), some infectious diseases, some ‘women’s complaints’ (including varicose veins), and a large quantity of claims arising from sheer poverty – such as anaemia, debility, intestinal problems (bad teeth) and nervous disorders³². According to one doctor, the physical condition of his female patients was so poor that – in the absence of a specific medical complaint – he felt obliged to sign a certificate to allow a spell of rest and recuperation, if only to regain strength.

Great attention was paid to the question of pregnancy and its associated complications: the developments that should be considered 'normal', the stage at which mothers should return to work following confinement and whether the whole reproductive process should properly be considered as illness. For friendly societies, this was nearly entirely new ground. The panel doctors, whose previous experience stemmed from attendance on those able to pay for medical attention at childbirth, stressed the need for rest and recuperation far beyond the terms for which approved societies or central government were willing to pay. Official opinion divided. On the one hand, those interested in society solvency reconstructed female working class health largely in male terms. Menstruation, pregnancy and childbirth were not certifiable illnesses unless they involved specific symptoms that characterised a pathology with a clear medical identity (not 'debility' or 'nervous exhaustion'). On the other, thanks to public concern over high infant mortality, central government, from 1907, was sponsoring ante-natal and post-natal advice to new mothers, extending local services by trained midwives and seeking to safeguard infant survival. The teaching underpinning this initiative stressed the need for rest before childbirth and the importance of breast-feeding afterwards. This did not fit in with the basic structure of NHI benefits: although the infant mortality lobby secured the payment of maternity benefit to the wives of insured workmen (which was doubled when the wife was also in insured employment). The object of maternity benefit was to enable parents to secure medical attention in the event of complications and to buy accessories for the newly born. The eventual outcome of this contradiction in public health policy lay in the exclusion of pregnancy and its associated complications from the remit of NHI: the provision of health visitors, maternity and infant welfare clinics, lying in hospitals remained firmly with local authority health services. In 1915, NHI introduced a special classification for female members who left work after marriage, one that only permitted them to retain NHI cover for three months after ceasing contributions (the unemployed were allowed 12 months). This removed the issue from the scheme for nearly all women.

This solution – reducing female sickness by disallowing female claims – proved a popular way of saving money under the health insurance scheme. Although the gap between male and female claim rates narrowed during the First World War, it reappeared in 1921 and continued to broaden during the rest of the decade. By 1928-30, women's claims were nearly double those of male members and those of married women alone were nearly three times as great³³. Unsurprisingly perhaps, they became the main target for RMO surveillance: sick women who were caught doing their housework had their claims disqualified. 'The Approved Societies

have discovered that married women are the worst “benefit spongers” screamed a popular tabloid newspaper at the height of the Slump: ‘... the funds are being taken advantage of by married women who are getting sickness benefit while at the same time engaging in their household duties.’³⁴ This type of publicity helped pave the way for further cuts in health benefits for female claimants – both married and unmarried - introduced the following year in a further attempt to secure society solvency. True to form, the Scottish Department of Health dictated that *all* claims for benefit from women aged 16-35 should be referred to the RMO; women of reproductive age were evidently scheming hussies intent on defrauding the scheme³⁵. This continuing denial of ‘female complaints’ was an attempt to reconstruct women workers’ health along male lines – with the evident object of making gender differences in claim rates disappear. Actuarial discipline was grounded on life insurance tables and friendly society experience of male health³⁶: from this perspective, women appeared as deviant and the causes of their deviancy were best ignored or excluded. This bias also reflects the political vulnerability of working women. Other high-claiming groups, such as mineworkers, were not identified for selective treatment. Sickness among women workers was received quite differently, reflecting how the apparently objective operation of actuarial science responded to established political priorities.

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In the problems faced by claims from older industrial workers and women, we can observe how economic recession and state control of approved society finances combined to distort the development of Britain’s health insurance scheme. In consequence, by the late 1930s health insurance was not very popular with anyone. Doctors fought a long (and ultimately fruitless) battle with the approved societies over low pay and long hours. Patients complained that panel doctors gave preference and time to private (fee-paying, middle class) patients. The needs of the families of the insured were still unmet at the outbreak of the Second World War. The health services available under the health insurance scheme failed to keep pace with medical progress. In contrast, public health services had blossomed, among the richer local authorities at least. The London County Council (run by Labour under the leadership of Herbert Morrison) had managed to create a fully integrated hospital and ambulance service by the outbreak of war: the National Health Service in miniature operating under the noses of Parliamentarians and civil servants in Whitehall. The Emergency Medical Service (EMS), developed during the 1939-45 conflict, built on this example, unifying and extending local

authority health provision and offering comprehensive and competent medical care. Wartime services standardised (and raised) the pay of all medical staff, widened access and reduced regional differences. The EMS thus provided a blueprint for the National Health Service of 1948.

Few mourned the disappearance of the National Health Insurance Scheme. Opinion polls and investigations in the late 1930s revealed complaints concerning the operation of health insurance: the paucity of medical services offered, the priority given by panel doctors to private patients, the inequitable levels of care offered for the same contribution by different approved societies³⁷. This centrally regulated market in health services proved anything but responsive to public demand and its failure contrasts not only with local authority health services, but also with schemes of health insurance found in other European countries – to which analysis we now turn.

Conclusions: comparative perspectives

This paper has stressed how the close control exercised by central government over the finances of British health insurance and its location within a complex framework of other systems of social protection conspired to stunt the development of health insurance in the UK. Unlike the social insurance systems in Continental Europe, British NHI became increasingly confined to the sidelines of health policy. By the late 1930s, central government was looking to the public sector – not the approved societies – to secure the future. Approved societies were widely blamed, both at the time and since, for the failure of NHI to expand as the scheme's creators had originally intended³⁸.

This failure of NHI to develop its coverage and scope reflects the failure of continental social democracy to take root in the UK. In the British version of health insurance, members of the scheme could exercise little influence on the way that their society was run and still less on how contributory income was spent. As the inter-war recession bit and society solvency came into question (particularly in industrial areas that suffered acutely from high unemployment), so central health insurance authorities sought to tighten their grip over society practice: the treatments that panel doctors might offer, the type of complaints that were admissible and the length of time patients could stay 'on the books'. In this way, the traditions of mutuality that had characterised the old friendly societies were undermined as the Health Insurance

Commissioners and the Government Actuary converted them into pale imitations of commercial insurance companies. Membership participation in society business diminished and their popularity waned. Although 199 Labour candidates pledged themselves to support friendly society participation in the administration of health benefits at the 1945 General Election³⁹, pressure to rationalise administrative structures in an era of chronic labour shortages overcame this belated attempt to salvage social democracy. Hence the approved society system was abolished when the National Health Service came into being.

Far from extending the mutual traditions of friendly societies to a wider section of the working class, as Lloyd George wished, the experience of administering the NHI scheme accelerated the decline of the friendly society movement. At the start of the twentieth century, collective membership had stood at around 5 million: by its end, it was slightly below 200,000. In this respect at least, it stands in contrast to the experience of the French *mutuelles*, whose membership has risen from a few hundred thousand at the close of the nineteenth century to over 39 million at the end of the twentieth. The reasons for these contrasting trajectories are not hard to find. In France, the *mutuelles* were also incorporated into the administration of the first French scheme of universal health insurance in the 1930s. Although this initiative had not been overwhelmingly successful, the republican requirement that funds must be governed by representatives of the membership was never breached. Following the 1939-45 war, the *mutuelles* were no longer involved directly in the new scheme of *securite sociale*, but remained central to health policy at local and national levels as agencies offering voluntary supplementary insurance to the state scheme. In this instance, the perpetuation of social-democratic forms of representation of the insured in the administrative process guaranteed its continued support and popularity. In Germany, equally, the creation of health insurance at a much earlier date had sought to integrate a range of established funds into a unified system of universal coverage. Again, securing political representation of the insured was central to the scheme's success. In both France and Germany, local funds exercised a far higher degree of local autonomy and local discretion than that permitted in the UK. In both, earnings-related contributions rendered such funds far less reliant on central subsidy than in Britain and in both we witness how such governing systems sustained (and continue to sustain) public support. While not seeking to diminish the profound differences that distinguish these two very different systems of health administration, the comparative dimension does seem to highlight the significance of social

democracy in establishing and sustaining the legitimacy of health insurance as a health care system.

From a comparative perspective, the common label ‘health insurance’ evidently disguised a wide variety of health care schemes in different countries. Each was firmly located within the political context of its country of origin: nearly all were created with reference to preceding social institutions and their architects closely referred to these precedents – to extend an existing ideal and/or correct its imperfections⁴⁰. This is reflected in different sets of rules and regulations, varying degrees of autonomy and different spheres of action. The strict adherence of the British scheme to insurance principles can be traced to earlier Friendly Society Acts, which established the authority of actuarial science in the provision of mutual aid. This orientation demonstrates an ulterior purpose underpinning NHI, which was to correct economic imbalances in local poor law finances. Other countries illustrate other priorities. In Germany, as is widely acknowledged, health insurance was designed to integrate working class representation into the social fabric of a newly established Reich, a solution later extended and reinforced by the political proclivities of the Weimar Republic. In contrast to its continental counterparts, under NHI in Britain (to paraphrase a TUC representative to the Beveridge committee) definitions of sickness responded more to actuarial calculation than to public demand.

From this comparative perspective, we can see how political context shaped the performance of health insurance in specific ways, permitting different degrees of democratic participation. The notion that patient choice (the alternative to participatory democracy promulgated in recent years) might be an effective substitute for democratic control is effectively refuted. All market systems require rules in order to secure public confidence in their operation – but the rules themselves must be subject to public deliberation. In the inter-war British NHI scheme, rules were formed and reformed behind closed doors: then imposed unilaterally on an unsuspecting public. The result was regulatory complexity (that confused approved society officials and members alike), diminished transparency, gross inequality and – in consequence – lost public confidence. The whole episode underlines the importance of democratic accountability to the viability of social insurance as a system of social protection.

¹ *Social Insurance and Allied Services* (Cmd. 6404 / 1942)

² As Peter Hennock has recently argued, the limited tax-raising authority of the newly established German Imperial government meant that Bismarckean social insurance relied overwhelmingly on contributions. This endowed local fund administrators with greater autonomy and more administrative discretion than was ever found in the UK. See E.P. Hennock, 2007, *The Origin of the Welfare State in England and Germany, 1850-1914: social policies compared* (Cambridge: Cambridge University Press)

³ P.H.G.H. Gosden *Self Help*, voluntary associations in nineteenth century Britain, London, 1973, p.90

⁴ See chapter by M. Dreyfus et al. in J.L. Robert, F. Boll, A. Prost (dir) *L'invention des syndicalismes: le syndicalisme en Europe occidentale a la fin du XIX^e siecle* (Paris, Sorbonne, 1998), pp.269-85

⁵ See, for example, Royal Commission on Labour, Final Report, C.1421, 1894 (HMSO) p. 24 and p. 28. Union unemployment statistics taken from N. Whiteside, 'Definir le chomage' in Mansfield, Salais and Whiteside, *Aux sources du chomage* (Belin, Paris, 1994) p.386

⁶ N. Whiteside 'Definit le chomage; traditions syndicales et politique nationale' in *Aux sources ...*n.b. the language here is not sexist : there were few female trade union members in trades offering such support.

⁷ See, for example, Royal Commission on Labour, *Final Report*, C.1421, 1894 (HMSO) p.24 and p. 28.

⁸ N. Whiteside 'Welfare legislation and the unions during the First World War', *Historical Journal*, 23, 1980, pp.857-874.

⁹ Ministry of Health (1939), *National Health Insurance and Contributory Pensions Insurance*, London, HMSO, pp. 32-4

¹⁰ Political and Economic Planning (1937) *Report on the British Health Services*, London, PEP, pp. 198-9.

¹¹ Beveridge Report (1942-3), tables I and II, p.25

¹² Beveridge papers: draft 56 (nd 1942), BP VIII/36/17; Memo to War Cabinet, 20 Aug. 1942, pp.2-3, BP VIII/36/21; Prudential memo to Beveridge Committee, May 1942, BP VIII/ 36/31 p.2. All British Library of Political and Economic Science (BLPES).

¹³ (1914-16) *Departmental Committee on Sickness Benefit Claims under the National Insurance Act: Final Report*, Cd. 7687, HMSO, London, p. 26

¹⁴ See in particular B.B. Gilbert, (1970), *British Social Policy, 1914-1939*, Batsford, London

¹⁵ In 1925, following the introduction of contributory widows and old age pensions and following the Economy Act, societies lost £2.75 million p.a. The final cut was introduced following the sterling crisis of 1931 and the May Report. By the beginning of the second world war, the interest on the large sums that had accrued in society accounts held centrally as contingency funds was used to offset the Exchequer contribution, to the tune of £7 million p.a. out of £9 million p.a. In short, NHI in Britain came to cost the taxpayer very little indeed.

¹⁶ Evidence Wright, 18 March 1914 to *Departmental Committee on Sickness Benefit Claims: Evidence*, Cd. 7689 / 1914-16, HMSO, London, pp 77 and 78.

¹⁷ Evidence of NATUAS, *Royal Commission on National Health Insurance (RCNHI): Appendix III*, P.P. 1926, Vol. XCII, p.615 para 18

¹⁸ W.H.Beveridge (ed), 1948, *Evidence for Voluntary Action*, London, Allen and Unwin, p.22.

¹⁹ Evidence Webb, 25 Feb 1914, *Departmental Committee ... Evidence*, op. cit., pp. 380-90

²⁰ p. 192, PIN 24/153, Public Record Office (PRO)

²¹ Set up in 1934 to deal with those unemployed with no right to unemployment benefit: note that 'domestic service' is not an insured trade. Documented on file AST 7/ 983, PRO

²² For a more developed account of how this affected doctors and patients, see A. Digby and N. Bosenquet, 'Doctors and patients in an era of national health insurance and private practice', *Economic History Review*, vol 41, 1, 1988.

²³ Evidence of Wright, op.cit. fn (9), p. 71

²⁴ Report by the Government Actuary on Sickness and Disablement Experience 1921-27' PIN 4/27, PRO

²⁵ *Report by the Government Actuary on the Third Valuation*, HMSO 1931-2, London, p.907

²⁶ 'Report of the Welsh Board of Health for 12 Dec 1930 - 12 Feb 1931', PIN 4/42, PRO

²⁷ Watson to Kinnear, 1 March 1936, ACT 1/582, PRO

²⁸ Evidence of the Ministry of Health, *RCNHI, Appendix 1*, op. cit., p.17

²⁹ Evidence of TUC to Beveridge Committee, 14 Jan 1942, pp. 22-3: CAB 87/77, PRO.

³⁰ Department of Health, Scotland, minutes, 26-27 March 1930, PIN 4/31: PRO

³¹ As women earned less than men, the rate of sickness benefit under NHI represented a higher proportion of their earnings, reinforcing arguments that this encouraged them to take time off when they were not really ill.

³² Evidence on women's claims 1912-13, presented by the National Federation of Women Workers to *Departmental Committee*, op cit (see fn (9)), p.318

³³ Epps to Kinnear, 23 May 1932: ACT 1/483, PRO

³⁴ *The People*, 19 April 1931

³⁵ Minutes, March 1931, op. cit.

³⁶ Sir Alfred Watson , the first Government Actuary held office from 1912 – 1937: he had previously been the actuary of the Manchester Unity of Oddfellows

³⁷ Political and Economic Planning (1937) *Report on the British Health Services*, London, PEP

³⁸ See, for example, B.B. Gilbert, *British Social Policy 1919-1939* (1971) and Frank Honigsbaum, *The Divisions in British Medicine* (1984)

³⁹ J. Lincoln, *The Way Ahead* (1946), pamphlet in BP VIII 53 pt IV.

⁴⁰ Clearly reflected in M. van der Linden (ed), 1996, *Social Security Mutualism*, Berne, Lang.