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## **Social insurance in Britain 1900-1950: frameworks of the welfare state**

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### **Introduction**

In historical debates on the origins of social insurance, the name of William Beveridge and his famous report are frequently invoked. This report, published in 1942, received much international publicity in the 1940s and is commonly understood to have been the blueprint for the post-war British welfare state<sup>1</sup>. Yet, viewed in terms of the origins of social insurance in the UK, Beveridge's proposals appear less radical than currently assumed: rather, they represent the extension, consolidation and rationalisation of systems of social insurance already in place, founded before the First World War. Beveridge himself, as a young man, had worked on the creation of the UK scheme of labour exchanges and unemployment insurance (1908-11) as a civil servant in the Labour Department of the Board of Trade. The propensity for British governments of all political parties to use social insurance to promote universal social protection has long and deep roots.

However, the British version of social insurance has always differed from its continental counterparts. First and foremost, as this paper will argue, liberal traditions have long dominated British social policy. British social insurance benefits have never been designed to offer more than minimal protection. In contrast to most continental European systems, Britain's official schemes have always been based on flat-rate (not earnings-related) contributions and benefits. The official gaze in Britain has focused less on the political threat posed by organised labour or even on problems of poverty: rather, rising levels of pauperism (that is, reliance by the destitute on public funds) have provoked most official concern because of their impact on local public finances. Liberal orthodoxies argue that personal responsibility lies at the foundation of individual liberty: British social insurance was designed to reinforce this message by obliging regular

workers to save against hard times. In the nineteenth century, relief of the destitute had been offered by the poor laws under punitive conditions: working people were expected to fend for themselves and those that failed (the paupers) were second only in public opprobrium to convicted criminals. The genesis of social insurance from 1911 modified this attitude, but did not completely remove it. Benefits levels were designed to offer the recipient a bare protection against destitution and were not supposed to sustain a specific standard of life and were therefore unlike other European social insurance systems. Instead, 'respectable' workers were encouraged to supplement state benefits with personal savings. In general, British social insurance benefits have been miserly and have long been guilty of failing to protect the recipient against poverty.

Second, variation in systems of social insurance in the early twentieth century also reflects different constructions of state power in different European states (as well as the very different objectives new schemes of social protection were designed to serve). As Peter Hennock has recently observed, limitations on the tax-raising powers of the newly created German Imperial state in the 1880s pushed the German Chancellor Bismarck into adopting an earnings-related solution to the problem of social insurance finance. This gave the new German health funds much higher income and thus greater liberty from central government control than in Britain where, as will be shown below, the state's contribution to health insurance endowed the central state with much greater authority over fund administration. Moreover, one of the commonly recognised political objectives of the pre-1914 German *Reich* – to reinforce its legitimacy – was singularly absent in the UK, where parliamentary democracy was secure and constitutional arrangements were not subject to serious challenges. Here, social insurance offered a solution to a political problem that focused not on constitutional legitimacy but on party rivalry in the context of a widening working class franchise<sup>2</sup>. The Labour party, created in 1902, was winning the votes of a growing proportion of the working class; the social reforms of the immediate pre-1914 years signify a (futile) attempt by a dominant Liberal party to turn the tide. Such comparative perspectives allow us to understand how different constitutional questions shaped debates about social reform and determined the state's role in social insurance schemes.

Third, in Britain, we observe from the start a far stronger degree of central government control over the development and operation of social insurance than appears in many other European states. In some respects this seems perverse: a liberal state acts in a far more authoritarian manner than some ostensibly more authoritarian states do. However, the object of this liberal version of social insurance (protection against social dependency at minimal public cost) was to reinforce personal responsibility and, in the case of health insurance at least, relied on the virtues of market competition and choice in the promotion of excellence. Hence, local mutual aid ('approved') societies that ran the UK health insurance scheme (1912-1946) competed for members in a manner quite unlike their Continental equivalents. However, markets are not always reliable. To ensure this 'market' operated as promoters believed it should, processes of audit over approved society accounts, supervised by the Treasury, endowed central government with extensive supervisory powers to guarantee the limitation of public liability in funding the scheme.

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 sterling as a major global trading currency and the role played by the Treasury as guardian of that legacy. In consequence, the state of the public finances played a dominant role in the formation and administration of social insurance policies and exerted constant pressure to minimise public expenditure on social insurance benefit levels. As this paper will show, the unemployment insurance scheme in particular during the inter-war period came to rely on Treasury subsidies, proving that social insurance offered less protection to the public finances than originally expected. The consequences of such inter-war problems was to tighten central control even more, obliterating the remnants of such social democratic government as had survived in the health insurance scheme (duly abolished in 1946). Even Beveridge's recommendations (1942) that flat-rate benefits should be fixed at subsistence level was never implemented. The Treasury has retained ever-tighter control over the administration of all social insurance schemes and their expenditure. This is now translated into rhetoric of 'targeting' (means-testing) state

benefits on those most in need and the corrosion of ‘benefits as of right’ in recent decades. British social security has retained its nineteenth century roots.

The paper that follows will place these characteristics in their historical context. The following (second) section will offer a brief overview of the origins of social insurance schemes by examining the roots of mutuality and the reforming agenda before 1911. The third section examines the politics and operation of Britain’s unemployment insurance scheme and the fourth describes the health insurance scheme that existed in the years before the introduction of the National Health Service. In the final main section, we return to the Beveridge Report and draw some comparative conclusions.

### **I) Origins of British social insurance**

The creation of Britain’s first scheme of social insurance in 1911 has excited widespread historical attention and has stimulated the publication of numerous books and articles. The antecedents of this formal system of social protection are perhaps less well known. Mutuality in Britain was highly developed: by 1892, over 7 million policies held by members of friendly societies were in existence<sup>3</sup>. Friendly societies, offering benefits to sick and elderly subscribing members, expanded steadily throughout the nineteenth century as a consequence both of working class revulsion against a punitive poor law and of legislative protection of society funds. Here, the word ‘policy’ is used advisedly to denote an increasingly commercial orientation: the object of voluntary registration under the many state Friendly Society Acts was not simply to protect such funds against the risk of embezzlement, but also to guarantee actuarial solvency. In this respect, the self-funding societies resembled insurance companies: the first society actuary (who subsequently became the first Government Actuary in 1911) was appointed by the Manchester Unity of Oddfellows (the largest friendly society) in 1894 with the task of guaranteeing the Manchester Unity’s finances. Even so, membership of non-registered societies remained buoyant; nearly 50% of society members belonged to such organisations in 1900. Aside from the myriad local benefit societies whose organisation remained highly informal, trade union schemes largely remained unregistered. Unlike

France, but like Germany, trade unions ran extensive mutual aid funds in Britain that offered a range of benefits that registered friendly societies were forbidden to offer by law: including most obviously strike and lock out pay and also unemployment benefits. By 1908, 1.84 million union members could claim protection against unemployment from their union<sup>4</sup>; union protection against sickness was far more widespread.

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 and the vast majority 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). The Friendly Society of Ironfounders and the Amalgamated Society of Engineers (founded in 1834 and 1852 respectively and essentially trade unions) differed only in that they offered to help members in dispute with their employer and – unlike other friendly societies - only recruited within specific trades.

Unemployment protection was only practiced by skilled trade unions, largely in construction, engineering, shipbuilding and similar trades (where cyclical and seasonal changes in labour demand were endemic). Unemployment benefits provided by these unions aimed to reinforce trade regulation: union benefits were designed to prevent unemployed members being forced, through desperation, to take work on non-union terms. Rights to benefit were subject to nationally agreed rules; branches acted as placement agencies for members and guaranteed the skills of the men concerned. Such systems operated unevenly (not all branches exercised the total control over local labour markets necessary for their enforcement). In principle, high contributions from relatively well-paid workers funded a range of 'friendly' benefits (help for the sick, injured, aged or unemployed); rights varied by sector, by length of membership and by level of skill. Members were supported for refusing work that failed to pay the union rate, for example, or in firms employing too many apprentices. Equally, members were fined for accepting such work or for working alongside non-members when there were union men 'on the books'<sup>5</sup>. 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. They also sustained membership: seniority frequently translated into higher benefit rates or extended rights. Although unemployment benefits were not universal, numbers covered expanded steadily in the early twentieth century. Trade union provision of friendly benefits was officially well regarded<sup>6</sup>. Their close association with trade dispute was not. The policy debate about unemployment, therefore, was partly shaped by state aims to re-calibrate trade union systems of classification, to distinguish the unemployed, the retired and the sick from strikers - provoking dissent within the union movement and opposition to state intervention as a result.<sup>7</sup>

Most state attention at the end of the nineteenth century, however, focused on the other end of the labour market, where enquiry revealed the close relationship between chronic poverty, sickness, physical incapacity and irregular (or casual) employment – closely associated with the rising levels of pauperism and a crisis in poor law finances in many major cities. Here, the social question was analysed along scientific lines: impartial

enquiry would reveal the source of the problem and professional impartiality would administer the cure. A logic of rationalisation, based on an uniform definition of the length and form of the working life, underpinned policy development (with the working life largely delineated by criteria of productive efficiency). This replaced the earlier (and more varied) systems of unemployment relief that had, since the mid-1880s, concentrated on the provision of municipal works and charitable help for the unemployed, similar to their French counterparts, that sought short-term solutions to the problems of destitution consequent on lack of work.

In Britain, the early twentieth century witnessed a political *volte face*: official concern began to view the twin problems of poverty and pauperism in different ways. Social investigation started to view these questions as a source of industrial inefficiency: of physical degeneration, of economic – and imperial – decline. Pauperism was a drain on local resources where poor law claimants lived- which, by the early twentieth century, were being propped up by loans from the Exchequer. Pauperised communities fostered criminality and immorality, provoking multiple causes for official concern, that could, in practical terms, be mapped onto Britain's major cities<sup>8</sup>. Such perceptions stimulated professional debate; their role in promoting social reform has been extensively documented<sup>9</sup>. The situation appeared almost perverse. Statistical appraisal demonstrated how industrial wage rates were rising in the closing decades of the century. Yet these years witnessed growing social unrest in major conurbations during economic recession – with rioters and looting indicating the inability of the poor to save against hard times or otherwise to protect themselves against the exigencies of a working life<sup>10</sup>. Moral imperative allied to fears concerning Britain's commercial future in social scientific debate. Workers at risk of destitution must be taught how to manage their lives – to invest in learning a skill and to save against the risk of job loss, illness and the inevitable decline in earning power in old age. This agenda and the political strategies it promoted stimulated a new identification of the 'unemployed' within the pauper host. The objective was less the relief of poverty *per se* than the provision of help (and support) to regular workers thrown out of work by trade fluctuations beyond their control. Here, labour

market organisation was an essential prerequisite to the establishment of greater economic efficiency and social order.

To avoid the punitive poor law, those desperate for work crowded the casual labour markets found in the UK's major ports, urban building sites and gasworks, where the heavy nature of the work, the competition for jobs and daily fluctuations in the demand for labour meant that secure employment was nearly impossible<sup>11</sup>. Here, good character, skill and regular work habits counted for nothing in the daily round of hiring and firing. Casual labour was widely recognised as a major source of inefficiency (large numbers of casuals were incapable of regular work), of social and moral degeneration (poverty bred criminality, sickness and incapacity) and this posed a major threat to Britain's industrial (and imperial) pre-eminence. Thus, according to the young Beveridge,

‘those who ... come to be casual labourers are almost inevitably demoralised by their circumstances. Irregular work and earnings make for irregular habits; conditions of employment in which a man stands to gain or lose so little by his good or bad behaviour make for irresponsibility, laziness, insubordination. ... The line between independence and dependence, between the efficient and the unemployable, must be made clearer. Every place in ‘free’ industry, carrying with it the rights of citizenship – civil liberty, fatherhood, conduct of one's own life and government of a family – should be a ‘whole’ place involving full employment and earnings up to a definite minimum.’<sup>12</sup>

Under-employment bred unemployability: if treated like a pauper, the unemployed regular man would eventually behave like one, ending up as another casual labourer incapable of holding down a permanent job<sup>13</sup>. The only way to break this cycle, reformers argued, was to protect the regular man and distinguish his treatment from that of the pauper, the habitual casual, the vagrant, the drunkard and the petty criminal: the sources of ‘the social problem’. The solution lay not in the provision of municipal public works as this merely added the chance of another short-term job and exacerbated problems of casualism and irregularity. Instead, inter-linked labour exchanges should rationalise the labour market: to remove the inefficient, the idle, the vagrant and habitually irregular workers and to concentrate work in the hands of the most efficient, thereby improving industrial and commercial performance. In short, far from seeking to remove or relieve



the problem of unemployment, a policy of labour market rationalisation would effectively create it<sup>14</sup>.

This strategy underpinned the reforms introduced by Liberal governments in Britain: the Labour Exchanges Act (1908), the National Insurance Act (1911) and the introduction of old age pensions (1908). Unlike either the municipal *bureaux de bienfaisance* or the *bourses du travail*, or even German municipal labour exchanges that kept unemployed workers in their local communities, the British labour exchanges offered a national network, to promote total labour mobility between as well as within trades and towns. New information technologies (the telephone) enabled the immediate exchange of information about vacancies and applicants, allowing state officials to send the most efficient to registered job vacancies. Networks of official surveillance were designed to identify applicants of good character, skill and sound working habits, in whose capable hands all available work should be concentrated, thereby eliminating the inefficient and promoting industrial prosperity to the advantage of employers seeking workers.

The National Insurance Act (Part I creating universal health insurance and Part II an unemployment insurance scheme covering five trades) reinforced this strategy. It was in the employer's interest to avoid hiring day labourers, as each hiring would require a full week's contribution for health insurance purposes – a payment that was doubled if the worker was also a member of the unemployment scheme<sup>15</sup>. Regulations determining how many weeks' contributions were required before access to benefit was allowed, based on actuarial calculation, would separate the regular contributor from the rest (the 'morality of mathematics' according to the young Winston Churchill who, as President of the Board of Trade, was charged with introducing the new legislation). Under Part II of the Act (the unemployment scheme), an established contributory record and the limitation of benefit to 15 weeks p.a. meant that support was only available to short-term claimants with a record of regular work. Long-term unemployment therefore did not officially exist: once benefit rights were exhausted, the unemployed claimant re-entered the pauper class. Rules disqualified claimants who quite work voluntarily, or whose unemployment was due to dismissal for misconduct or to industrial dispute. From the detail of the 1911

legislation, the British unemployed emerge: a select group of regularly employed men whose services were temporarily surplus to immediate requirements, in a scheme initially confined to trades known to suffer from seasonal fluctuations in demand.

In the pre-1914 era, twin issues of unemployment and sickness were heavily inter-twined: sickness caused unemployment and unemployment frequently, through falling household income, caused sickness. National insurance was designed to break this vicious circle by offering benefits as of right to worthy workers whose contributory record demonstrated their good character. In the UK, the main object was to tackle the social question as an issue of industrial and national efficiency (and, through this, to address a threat to British commercial and imperial pre-eminence) on the one hand – and to restore local public finances on the other. The threat posed by labour market disorganisation was not political, but economic: social insurance formed part of a programme to tackle this. The solution lay in rationalising the distribution of work, to remove the dross, to protect workers needed to meet fluctuations in trade (the ‘unemployed’) and to allow access to medical treatment for sick workers (but not their families or dependents). As for the remaining poor, policy remained hazy: punitive poor law treatment was tightened up in 1911, following the introduction of social insurance.

In the UK, the vision of a professional, centralised and expert system of labour market organisation never materialised: decasualisation was strongly opposed by employers and workers alike and labour exchanges never exerted the influence over job allocation that developed in municipalities in continental Europe (notably Belgium, the Netherlands and Germany). Although the rationalisation project was attempted during the First World War, union opposition ensured its demise. Following the war, as unemployment rose in the 1920s, attempts at labour market rationalisation were abandoned and policy switched to fostering work sharing and short-time working<sup>16</sup> as the official gaze shifted from casual labour markets and towards the ‘depressed areas’, the locus of long-term unemployment.

## II) Unemployment Insurance in Practice

### *The trade union movement and the politics of unemployment insurance*<sup>17</sup>

The situation in the First World War offered the chance for the Board of Trade civil servants to prove how their programme of labour market reform could meet the national emergency. Chronic manpower shortages demanded the release of as many men as possible to fight in the armed services. The transfer of the young Beveridge and his colleagues to the Ministry of Munitions in 1915 appeared to strengthen central authority over the deployment of labour resources. However, in 1916 the newly formed Coalition government, led by Lloyd George, created a new Ministry of Labour (long demanded by the trade union movement) that gave an increasingly militant labour movement a voice in how military conscription, introduced that same year, was to operate. The result was an impasse: a contradiction was emerging about the principles on which labour market policy should be based; industrial democracy stood in opposition to bureaucratic centralised controls.

In 1916, Beveridge initiated the extension of compulsory unemployment insurance to all munitions workers (on the grounds that, when peace returned, they were at high risk of unemployment). However, opposition from the now confident trade unionists to this measure rendered it inoperable<sup>18</sup>. Most munitions workers refused to register under its terms and their employers, nervous of provoking strike action and disinclined to pay contributions anyway, did nothing to force the issue. In the event, as Lloyd George became Prime Minister, policy was thrown abruptly into reverse. The old reforming group of civil servants was disbanded (Beveridge was transferred to the Ministry of Food) and the new Ministry of Labour took control of labour policy. At the end of the war, Out of Work Donation (OWD was tax-funded, included family benefits and offered higher benefits than the pre-war unemployment insurance scheme) – originally destined only for the demobilised armed forces – was extended to cover all unemployed.

As this episode indicates, the 1911 unemployment insurance scheme was not wildly popular in the trade union movement; its extension in 1916 provoked opposition, as did

its eventual application to all industrial workers in 1920 - a stark contrast to the response given by the TUC to the Beveridge Report in 1942. In part, opposition reflected the expansion and growing strength of general labour trade unionism (the Transport and General Workers' Union, one of the largest of these, was founded in 1922), in consequence of full employment during the war. These unions argued that low-paid workers should not be forced to fund the unemployment of fellow workers, which should be the responsibility of the state (and the taxpayer). With the extension of industrial organisation to new sectors came the demand that industrial bargaining, not statutory insurance schemes, should secure protection. Hence the minimum wage imposed by the Cotton Control Board in 1917 on all employers in that industry offered protection to workers whose income was reduced by short-time working. This offered a model. In 1920, the leader of the dock workers union fought (unsuccessfully) for a minimum wage, paid for by the industry, for all registered port workers – again to protect them from the consequences of intermittent work<sup>19</sup>. The TUC argued that unemployment insurance should be voluntary and that industries that could negotiate alternative agreements should be allowed to 'contract out' of it provisions. Needless to say, this was opposed by the Treasury, as 'low risk' trades (with low unemployment) would leave the scheme, leaving the state responsible for those occupations where high levels of unemployment were endemic – a prospect inviting financial disaster.

New general labour unions were not alone in wishing to put unemployment insurance on a voluntary footing. What constituted 'unemployment' was not self evident and here skilled trade union traditions, outlined in the preceding section, operated according to very different principles to the state scheme. The 1911 unemployment insurance scheme refused benefit to any 'unemployed' in dispute with their employer: in direct contrast, trade union schemes were deliberately designed to help to members who walked out when their employer refused to comply with union agreements and terms of employment. As the 1911 Act made the employer (not the union) the determinant of whether (or not) a 'dispute' existed, discrepancies in the interpretation of what 'unemployment' meant and exactly who the victims were quickly became apparent. For union benefit systems were designed to prevent men, desperate from the want of work, taking employment at lower

rates of wages or longer hours of work than the union was prepared to tolerate. Such schemes were designed to help skilled men, through professional solidarity, preserve their skills and status by protecting the trade<sup>20</sup>. By contrast, the state scheme was far less particular about protecting the status of the skilled: applicants were supposed to take any work that they were physically capable of doing – and state benefit was withheld if a job offer was refused. Such contrasting systems provoked conflict and help explain why skilled unions allied with unskilled in opposing unemployment insurance after the First World War. At the same time, vastly expanded union organisation and the numbers covered by union unemployment benefits had risen during the war year, reaching 4,108,00 in 1921 – or half the membership of the TUC<sup>21</sup>.

Like the health insurance scheme (see next section), unemployment insurance could also be administered by private agencies registered under the 1911 National Insurance Act. A number of trade unions chose so to register. However, the initially attractive prospect of using the administration of state benefits (in supplement to the union's own scheme) to attract new members proved counter-productive. State benefit payments were only reimbursed to registered unions retrospectively, on the submission of audited accounts – and 'improper' payments were not repaid. The General Secretary of the Scottish Union of Ironfounders suffered a nervous breakdown in 1912, when it became apparent that his union had lost large sums of money in consequence. Tightly centralised administration thus required trade unions to alter their regulations to comply with government requirements. This meant a profound change in union practices and to administer two schemes side by side was administratively complex and very costly. During the 1920s, the number of unions administering official benefits declined sharply. This was largely because high levels of unemployment undermined membership in those sectors of industry whose unions had traditionally offered such benefits, and now could no longer afford to do so - although, exceptions can be found among the vehicle builders (the car industry thrived in the 1930s) and in 'sheltered' (non-export) trades – notably printing and allied occupations.

While the 1918-19 temporary Out of Work Donation Scheme sustained a degree of industrial peace, the Treasury's commitments to contain post-war inflation and to restore the pound sterling to pre-war parity against the US dollar forced the extension of the original unemployment insurance plan. Hence contributory unemployment insurance was extended to all manual workers in 1920, raising the numbers covered from 2.1 million registered in 1914 to 12.5 million by 1931 (out of a working population of 19.5 million)<sup>22</sup>. As in 1911, actuarial calculation promised to contain the state's obligations by making contributory income (under tri-partite contributions from state, worker and employer) cover benefit expenditure. However, the scheme was never administered as originally intended. Unemployment rose in the winter of 1920-21 and it proved politically impossible to force demobilised soldiers and radicalised trade union members, who had not had the chance to build up the required level of contributions to claim such benefits, back onto poor law relief when the OWD scheme was wound up in 1920. In consequence, as early as 1921, the government introduced legislation to enable workers to claim benefits *in advance of* establishing a contributory record. Under various labels ('uncovenanted', 'transitional', or 'extended' benefits) slightly varied systems addressing the non-contributing unemployed were extended by annual (sometimes bi-annual) legislation into the 1930s – when those long-term unemployed who had exhausted their rights were brought under a separate Unemployment Assistance Scheme<sup>23</sup>.

In the interim, however, UK unemployment insurance lost most of the characteristics typical of a social insurance system. Rights to benefit no longer reflected a record of contributions and instead became dependent on the applicant's ability to prove a search for work. Within this new climate, the identity of the 'unemployed' was transformed to reflect the new political dilemmas facing government during the inter-war years. As we will see in the following section, the administrative redefinitions of who was recognised as 'unemployed' (and could claim state benefits) shifted considerably in the new climate towards the trade union demand that the state maintain the unemployed.

### *Defining Unemployment: the scheme and its claimants*

As already indicated, 'unemployment' as conceived in the late nineteenth century had no uniform or self evident meaning. The 'unemployed' were distinguished from the rest of the pauper host by their moral superiority: made evident in their previous regular working habits, their independence, thrift, sobriety and honesty. Policies for the unemployed therefore aimed to save these stout fellows from the horrors of the poor law, on whose tender mercies they might be thrown in hard times, through no fault of their own. Such policies, however, excluded the 'residuum' – men surplus to labour market requirements whose physical and mental weaknesses rendered them incapable of regular work and a burden on the industries they served. The 1911 Act offered an official definition of unemployment that was highly normative. The 'unemployed' were those deemed surplus to industrial requirements for up to 15 weeks a year, who were not in dispute with their employer and whose unemployment could not be attributed to dismissal or to their own voluntary actions. Under this system, 'long term' unemployment was impossible; those out of work for any length of time simply lost their right to benefit and - if all else failed - rejoined the pauper class.

This solution was financially self sufficient and administratively convenient, but politically unviable. It did not last. In the early 1920s, rising unemployment and official fears of working class unrest encouraged governments to make concessions and to extend claimants' rights: largely to the benefit of the better organised (and more politically powerful) sectors of the labour market. Broadly speaking, this served to liberalise previous definitions. In 1921, the Cabinet condoned the extension of benefit to short-time workers, in an attempt to encourage employers to share work as widely as possible during what was popularly conceived as a temporary crisis<sup>24</sup>. One-third of the three million claims lodged at the exchanges in June that year came from this group. Where industrial relations were good - and work sharing was traditional - working arrangements could be adapted to allow the underemployed to claim state benefits to supplement reduced earnings. This was widely considered to be preferable to mass redundancies. Underemployed workers continued to contribute to the Unemployment Fund and thus

could maintain a right to state benefits. Their claims were less likely to be subject to official discretion in the 1920s (when rights to 'extended' benefits for long-term claimants were subject to close scrutiny) and they avoided the attentions of the 'means test man' under the Poor Law. Any attempt to follow in the footsteps of the pre-1914 reformers by expelling those surplus to immediate requirements from the labour market altogether, would have provoked political dissent and public outcry.

As a result, the aims of unemployment policy were thrown into reverse; state benefits came to reinforce existing working practices and subsidised reduced earnings. Systematic short-time could be found in cotton textiles, in some midland collieries, in leather, clothing, small metal manufacture - even some shipyards and foundries in the 1920s<sup>25</sup>. By the middle of the decade, the Dyers', Bleachers' and Finishers' Union was boasting that, through careful negotiation, they were 'carrying' a 60% labour surplus in their trade<sup>26</sup>. And on the docks, the Transport and General Workers Union won an agreement which allowed registered dock workers 'three days on the hook and three days in the (unemployment) book' throughout the interwar years<sup>27</sup>.

These developments were not universally popular, least of all with employers whose contributions to unemployment insurance were raised to pay for what they conceived as unmerited generosity. As the scheme was constantly modified, so definitions of unemployment were increasingly subject to political debate and compromise. By the mid-1920s, more liberal interpretations, promoted by the TUC and local Labour parties, came increasingly under fire from the Treasury and the National Confederation of Employers' Organisations (NCEO) - both of whom wanted to reduce benefits, to restrict access to them and generally to return to the Edwardian world<sup>28</sup>. By the end of the decade, these conservative forces were increasingly influential in shaping policy; marginal, unorganised workers were finding access to benefit very difficult. However, attempts to contain claims from short-time, seasonal and casual workers were not totally successful. In this respect, the 1931 Anomalies Act - which contained clauses designed to eliminate claims from these groups - failed<sup>29</sup>. Where employers were cooperative, it proved generally impossible to prevent working agreements being renegotiated to get round



official restrictions. Far from reforming employment practices in casual labour markets and rationalising the distribution of work, as Beveridge and his colleagues had originally intended, unemployment insurance was transformed in some cases into a sort of wage supplement, designed to appease the more politically volatile sectors of the labour market. During the interwar period, the concept of unemployment became detached from its early social scientific foundations and accommodated variations in industrial practice.

The main benefactors from these changes were unionised workers, who could exert some control (collective or individual) over their working lives. Conversely, unskilled, unorganised elements became the chief victims of official parsimony. Women in general - and married women in particular - received more than their fair share of official attention. Most women who continued to work after marriage tended to be from the poorest working class households: employed in industries like pottery-making, textiles and the clothing trades as well as in domestic service – this last classification covering various low paid jobs in catering, cleaning, pub and hotel work as well as parlour maids and cooks. Married women were the chief victims of regulations introduced to police claims to ‘uncovenanted’ benefits: the 1921 means test and the 1922 ‘not genuinely seeking work’ rule that sought to disqualify claimants who were unwilling to travel to search of a job. Under a regulation that year which required exchanges to offer female claimants domestic service, women left the unemployment scheme in droves. Domestic work was not an ‘insured trade’ and these women were thus trapped. If they accepted the position, they left the unemployment scheme and if they refused it, their claim was disqualified.<sup>30</sup> And under the 1931 Anomalies Act, the rights of married women to claim even standard benefits were severely curtailed. The treatment of women illustrates the way public officials and politicians continued to impose normative values and prescriptive rules in defining the problem, thus hiding a large quantity of unemployment from the public eye.

Not all workers who lost their jobs became classified as ‘unemployed’. Aside from those who were refused unemployment benefit, some resorted to vagrancy, others registered as sick or disabled. Older workers and those whose health rendered their productivity

suspect were both more likely to lose their jobs and less likely to be able to find another. As competition for work rose, discrimination against the 'sick' began to operate further and further up the health spectrum of the labour force (see following sections). Hence the 1930s were characterised by a high incidence of long-term sickness, complementing the numbers of long term 'unemployed'. The cause of both forms of social dependency was the same: the lack of waged work<sup>31</sup>. In the course of the second world war, as the demand for labour rose, levels of sickness, disability, vagrancy and registered unemployment - all declined, as those previously seen as 'unemployable' were, in the new climate, considered capable of holding down a job of some sort. Neither absolute nor abstract, interwar unemployment figures were, as ever, a construct of social and political pressures, not the mere reflection of economic change.

In the 1930s, as the Slump bit and unemployment rose, work-sharing strategies diminished and long-term unemployment moved centre-stage in political debate. Following Britain's financial crisis of 1931, the whole scheme was recalibrated in a renewed attempt to accommodate different aspects of unemployment, to allow the temporarily unemployed (who retained benefit rights) to be distinguished from long-term cases. In 1934, reform separated unemployment insurance from unemployment assistance and subjected claimants to the latter to household means-tests (associated with the disgrace of pauperism) that provoked hostility and widespread protest. At the same time, numbers of older workers with little hope of re-employment transferred to health insurance to claim sickness or invalidity benefits.<sup>32</sup> The ensuing quarrels with the Ministry of Health about whether (or not) a claimant was 'physically capable of work' when (s)he suffered from bronchitis, varicose veins, flat feet and a host of other middle-range infirmities – led to pointless but prolonged bouts of claimant shuffling and re-categorisation (discussed in the next section). Unemployment, notably long-term unemployment, caused poverty and poverty exacerbated illnesses – as much then as it has done recently. Sickness and disability rates collapsed as a consequence of labour shortages following the onset of the war.<sup>33</sup> In the course of the interwar years, the cause for concern in the British construction of the unemployment problem shifted – away from the casual worker who had been central to policy discussion before 1914 and towards the

long-term claimant in a depressed area with no hope of finding work. Again, the experience of the 1930s shaped the politics of the 1940s: in this case, a shift in policy – away from compensation systems for the unemployed and towards sustaining demand for labour: the adoption by UK governments of Keynesian strategies to promote jobs for all.

### **III) 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 1938<sup>34</sup>, including about 640,000 voluntary contributors<sup>35</sup>. 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.<sup>36</sup>

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 policies<sup>37</sup>. 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.'<sup>38</sup> 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 opinion<sup>39</sup>, 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 1931<sup>40</sup>. 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.'<sup>41</sup> In the words of the National Association of Trade Union Approved Societies (NATUAS) in 1925, 'membership control is a sham and a farce.'<sup>42</sup> 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.'<sup>43</sup>

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 care<sup>44</sup>. 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 1915<sup>45</sup> 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 Board<sup>46</sup> 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 lists<sup>47</sup>. ‘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 1914<sup>48</sup>. 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 men<sup>49</sup> 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%<sup>50</sup>. 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 period<sup>51</sup>. 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 acidly 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.'<sup>52</sup> 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 certificates<sup>53</sup>. 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 invalidity<sup>54</sup>. 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 advice<sup>55</sup>. 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. 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, whose sickness experience was particularly high, exacerbated by the tactics employed by the Ministry of Labour from 1921 to exclude women from unemployment benefit. Unable to claim 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 sickness<sup>56</sup>, 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 disorders<sup>57</sup>. 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 great<sup>58</sup>. 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.'<sup>59</sup> 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 scheme<sup>60</sup>. 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 health<sup>61</sup>: 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 societies<sup>62</sup>. 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.



#### **IV) Conclusions and 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 its development. Unlike the social insurance systems in Continental Europe, Britain's 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 intended<sup>63</sup>.

This failure of NHI to develop its coverage and scope can be largely ascribed to the failure of continental social democracy to take root in the UK. In the British version of health insurance, as in the British version of social insurance more generally, members of the state schemes could exercise little influence over the way that their insurance operated and still less on how contributory income was spent. As the inter-war recession bit and both unemployment and health insurance funds faced insolvency (thanks to the persistent high unemployment found in northern industrial areas), so central authorities sought to tighten their grip over social insurance administration. In health insurance terms, this meant dictating 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 Election<sup>64</sup>, pressure to rationalise administrative structures in the post-war context 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 voluntary mutuality in general and the friendly society movement in particular. At the start of the twentieth century, their 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 was not overwhelmingly successful, the republican requirement that funds must be governed by representatives of the insured was never breached. In this instance, the perpetuation of the social-democratic requirement that collective insurance should be governed by representatives of the insured secured continued support and popularity. In Germany, equally, the creation of health insurance (at a much earlier date) also secured political representation of the insured as a central component of 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: earnings-related contributions rendered them far less reliant on central subsidy than in Britain. While not seeking to dismiss the profound differences that distinguish these two very different systems of health administration, a comparative perspective highlights the significance of social democracy in sustaining the legitimacy of health insurance in the public mind.

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 needs. The powers of actuarial calculation also influenced the ways in which the unemployment insurance scheme operated, although here, as the preceding account shows, the depths of the recession, its assumed temporary nature and the political opposition of the trade unions combined to force concessions for specific groups of workers (although not all). Under both schemes, claims from women workers were subject to intense official scrutiny – revealing official assumptions about

the gendering of waged work and what has more recently been termed the 'male breadwinner model' of household dependency. Hence the unemployment scheme deliberately excluded 'domestic servants'; moreover, even married women who worked elsewhere could still find what appeared to be perfectly legitimate claims denied by virtue of their husband or son continuing to be employed after 1931. The shaping of the labour market, as well as the definition of what 'unemployment' meant, both belied the apparently impartial way in which the scheme operated – reflecting similar assumptions about gender that can also be traced in the health insurance scheme as well. For unemployment insurance in particular, the constant redefinitions and redrafting of contributors' rights translated, in a more general fashion, into the growing powerlessness of the claimant. With legislation changing every year throughout the 1920s, the problems of establishing the legitimacy of a claim to benefit or challenging an official ruling became increasingly complex and sources of help increasingly remote. This incremental strengthening of central expertise and authority played its part, together with persistent high levels of unemployment, in undermining trade union opposition to uniform definitions and central control that were so evident around the time of the First World War.

Hence the British trade union movement, struck by the possibility of subsistence level benefits and the abolition of means tests, threw its weight behind the Beveridge Report of 1942 without a backward glance towards its own older democratic traditions of benefit governance. As for Beveridge, traces of the young man's ideas are easily visible in the older man's recommendations. Again, the object of the exercise is to increase efficiency. Again, the means to do this was to place the whole question in the hands of central government: to unify all social insurance systems under one single bureaucracy capable of impartial administration in the name of social justice. In this way, the 'duplication and waste' that had characterised separate administrative systems in the interwar years would be removed. A single hierarchy dealing with all claims 'from the cradle to the grave' could eliminate problems consequent on 'claimant shuffling', reduce administrative costs and generally, thereby, raise efficiency. Quite why, given past experience, the British

public in general – and the trade union movement in particular – could suspend disbelief in the machinations of central government in this matter is a question for another paper.

The significance of financial self-sufficiency and commercial imperatives for both schemes of social insurance returns us to the liberal nature of British social insurance and the observations, made at the start of this paper, concerning the ways in which such schemes were initially proposed as the means to limit (rather than extend) public liability for the socially dependent. In this regard, the liberal state, far from being a weak or absent institution, proves to be extremely strong and highly interventionist. It shapes the rules under which social protection may be offered and determines the (necessarily narrow) confines within which benefit ‘as of right’ can be conferred. Cases that do not comply continue to be subject to interrogation and quasi-punitive treatment. In this way, through fear, personal responsibility is enforced and the liberty of the subject is secured.

## ENDNOTES

<sup>1</sup> *Social Insurance and Allied Services*, Cmd. 6404/1942

<sup>2</sup> The right to vote had been extended to all male heads of household in urban and rural areas in two Acts of Parliament in 1867 and 1884

<sup>3</sup> P.H.G.H. Gosden *Self Help, voluntary associations in nineteenth century Britain*, London, (1973), p.90

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<sup>5</sup> Ibid. n.b. the language here is not sexist : there were few female trade union members in trades offering such support.

<sup>6</sup> See, for example, Royal Commission on Labour, *Final Report*, C.1421, 1894 (HMSO) p.24 and p. 28.

<sup>7</sup> N. Whiteside 'Welfare legislation and the unions during the First World War', *Historical Journal*, 23, 1980, pp.857-874.

<sup>8</sup> C. Topolov, *Naissance du chomeur*, Albin Michel (1994) used the maps of East London, developed by Charles Booth's investigations in the late nineteenth century, to demonstrate correlations between casual work, slum housing, criminality, poor school attendance and multiple general social evils. See especially ch. 10

<sup>9</sup> e.g. J.Harris *Unemployment and politics* (OUP 1972).

<sup>10</sup> H. Barkai 'Travail, emploi, salaires dans l'economie neo-classique' in *Aux sources* .op. cit.

<sup>11</sup> See G. Phillips and N. Whiteside, *Casual Labour*(OUP, 1986) chs 2-4.

<sup>12</sup> W.H.Beveridge, 'The Problem of the Unemployed', *Sociological Papers*, 1907, pp. 326-7.

<sup>13</sup> W.H. Beveridge, *Unemployment: a problem of industry*, Allen and Unwin, 1909.

<sup>14</sup> M. Mansfield 'Naissance d'une definition institutionnelle du chomage en Grande Bretagne' in *Aux sources* .. op. Cit.

<sup>15</sup> Part II of the 1911 National Insurance Act offered unemployment insurance that covered a restricted number of trades – largely those with skilled unions offering unemployment benefits, i.e. shipbuilding, engineering, construction and metal working. The Act was extended to all manual workers earning less than £250 p.a. in 1920

<sup>16</sup> N. Whiteside, 'Deconstructing unemployment: developments in Britain in the interwar years', *Economic History Review*, XLIV, Nov. 1991, pp. 665-682.

<sup>17</sup> For a more detailed account of developments covered by this section, see N. Whiteside, 'Social Welfare and Industrial Relations' in C.J. Wrigley (ed), *A History of British Industrial Relations, vol. II, 1914-39* Harvester, Brighton, 1987: pp. 211-43.

<sup>18</sup> N. Whiteside, 'Welfare legislation and the unions during the First World War', *Historical Journal*, 1980, 23. Further discussion of this paper can be found in *Historical Journal*, 25 (1982)

<sup>19</sup> Phillips and Whiteside, op. cit., ch. 3.

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<sup>21</sup> Evidence of the National Joint Standing Advisory Committee, 13 April 1926 to Blanesburgh: Ministry of Labour, *Committee on Unemployment Insurance, minutes of evidence* vol III (1927) p. 149

<sup>22</sup> W.R Garside, *Measuring Unemployment*, Oxford, Blackwells (1980), pp. 29-31. Agricultural workers, domestic servants and white collar workers were excluded – as was anyone earning more than £250 p.a.

<sup>23</sup> For a fuller account, see N. Whiteside, *Bad Times: unemployment in British social and political history*, Fabers, London, (1992), ch. 4.

<sup>24</sup> See N. Whiteside 'Welfare insurance and casual labour': *Economic History review, 2nd series*, XXXII (1979) pp. 507-22

<sup>25</sup> Royal Commission on Unemployment Insurance, 19 Dec. 1930, *Minutes of Evidence*, vol 1 (HMSO, 1932): p.4

<sup>26</sup> TUC file 135.61: 'Unemployment Associations (TC): unions' opinions'. Correspondence between Citrine and the Bradford Dyers and Finishers: Modern Records Centre, Warwick.

<sup>27</sup> Whiteside 'Welfare insurance and casual labour' op. cit.

<sup>28</sup> For an overview see Whiteside, 'Social welfare and industrial relations' op. cit.

<sup>29</sup> Memo by Price 17 March 1932: on file PIN 6/23, The National Archive (TNA), Kew.

<sup>30</sup> For refusing a job they were capable of doing. See CAB 23/29 CC9 (22) conclusion 1: TNA

- <sup>31</sup> see N. Whiteside, 'Counting the cost: sickness and disability among working people in an era of industrial recession', *Economic History Review*, 2nd series, XL (1987), pp 228-46
- <sup>32</sup> For evidence of this see Whiteside, 'Counting the cost ...' op. cit.
- <sup>33</sup> Ibid..
- <sup>34</sup> Ministry of Health, *National Health Insurance and Contributory Pensions Insurance*, London, HMSO (1939), pp. 32-4
- <sup>35</sup> Political and Economic Planning *Report on the British Health Services*, London, PEP, (1937) pp. 198-9.
- <sup>36</sup> Beveridge Report (1942-3), tables I and II, p.25 op. cit.
- <sup>37</sup> 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).
- <sup>38</sup> *Departmental Committee on Sickness Benefit Claims under the National Insurance Act: Final Report*, Cd. 7687, HMSO (1914-16), London, p. 26
- <sup>39</sup> See in particular B.B. Gilbert, (1970), *British Social Policy, 1914-1939*, Batsford, London
- <sup>40</sup> 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.
- <sup>41</sup> Evidence Wright, 18 March 1914 to *Departmental Committee on Sickness Benefit Claims: Evidence*, Cd. 7689 / 1914-16, HMSO, London, pp 77 and 78.
- <sup>42</sup> Evidence of NATUAS, *Royal Commission on National Health Insurance (RCNHI): Appendix III*, P.P. 1926, Vol. XCII, p.615 para 18
- <sup>43</sup> W.H.Beveridge (ed), 1948, *Evidence for Voluntary Action*, London, Allen and Unwin, p.22.
- <sup>44</sup> Evidence Webb, 25 Feb 1914, *Departmental Committee ... Evidence*, op. cit., pp. 380-90
- <sup>45</sup> p. 192, PIN 24/153, TNA
- <sup>46</sup> 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
- <sup>47</sup> 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 XLI, 1, 1988.
- <sup>48</sup> Evidence of Wright, op.cit. fn (41), p. 71
- <sup>49</sup> Report by the Government Actuary on Sickness and Disablement Experience 1921-27' PIN 4/27, TNA
- <sup>50</sup> *Report by the Government Actuary on the Third Valuation*, HMSO 1931-2, London, p.907
- <sup>51</sup> 'Report of the Welsh Board of Health for 12 Dec 1930 - 12 Feb 1931', PIN 4/42, TNA
- <sup>52</sup> Watson to Kinnear, 1 March 1936, ACT 1/582, TNA
- <sup>53</sup> Evidence of the Ministry of Health, *RCNHI, Appendix 1*, op. cit., p.17
- <sup>54</sup> Evidence of TUC to Beveridge Committee, 14 Jan 1942, pp. 22-3: CAB 87/77, TNA
- <sup>55</sup> Department of Health, Scotland, minutes, 26-27 March 1930, PIN 4/31: TNA
- <sup>56</sup> 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.
- <sup>57</sup> Evidence on women's claims 1912-13, presented by the National Federation of Women Workers to *Departmental Committee*, op cit (see fn (41)), p.318
- <sup>58</sup> Epps to Kinnear, 23 May 1932: ACT 1/483, TNA
- <sup>59</sup> *The People*, 19 April 1931
- <sup>60</sup> Minutes, March 1931, op. cit.
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- <sup>62</sup> PEP, *Report on the British Health Services*, op. cit.
- <sup>63</sup> See, for example, B.B. Gilbert, op. cit and Frank Honigsbaum, *The Divisions in British Medicine* (1984)
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