The last years of diversity: recent historical writing on British health services on the eve of the NHS

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Why history might matter:

- example of **performance** of pluralist system
- **understand** political context of **transition** from pluralism to hierarchical state system

1. **Before 1948: the mixed economy of health care**
2. **Conceptualisation and historiography**
3. **Recent research:**
   - **Primary care**
   - **Voluntary hospitals**
   - **Local government**
   - **Citizenship/public opinion**

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1. Before 1948: the mixed economy of health care

- State (central): NHI (54% coverage 1938)
- Market: Primary care, nursing homes
- Voluntary sector: hospitals (acute), friendly societies, hospital contributory schemes
- State (local):
  - Local government: public health – environmental/ curative, mental health
    - 1929 Break up of Poor Law, municipal general hospitals
  - Poor Law: institutions health/social care 'chronic', mental health

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2. Explaining the ‘big bang’: national historiography

- Emergence of an explanation: Titmuss 1950, Lindsey 1962, Eckstein 1964, Abel Smith 1964, Klein 1983
  - Consensus favouring reform builds since 1920
  - Key components:
    - Failure of voluntary financing and provision
    - Absence of ‘integration’
    - Limitations to public/private mix in primary care
    - Unevenness of local government
    - Impact of 1939-45 War
      - Emergency Medical Service models planning

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Explaining the ‘big bang’: comparative health systems historiography

- **Structural factors**
  - Economic development, demographic momentum, medical science – ‘hierarchical regionalism’
- **Bringing the state back in:**
  - **‘Labour mobilisation’**
    - Strength of labour movement/social democracy
  - **‘Pluralism’: state neutral arbiter interest group politics**
    - Actors: pre-reform coalition; providers; medical profession
  - **‘Historical institutionalism’**
    - State autonomous actor
    - Political culture matters
    - Political institutions determine scope and timing
    - Path dependence: early decisions at ‘critical junctures’ determine later possibilities and outcomes

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The UK ‘big bang’ in comparative context

Institutional context :

Professional bureaucracy , tradition of public provision, political system can deliver ‘windows of opportunity’

Critical juncture 1911:

NHI an ‘expansionary political dynamic’ that reached its ‘almost inexorable’ culmination in a universal tax-funded service (Hacker 1998)

Reform era 1938-1945:

Pluralism/interest politics OR state autonomous actor

Critical juncture 1945:

Labour victory opens the window

– Consensus favouring reform from 1920
  - Failure of voluntary financing and provision
  - Absence of ‘integration’

Structural : medicine hierarchical regionalism

- Limitations to public/private mix in primary care
- Unevenness of local government
- Impact of 1939-45 War

Political culture: ‘... strong public preference for universal coverage ... voluntary hospitals taken over...’ (Jacobs 1992)

Fox 1985, Jacobs 1992, Hacker 1998, Tuohy 1999

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3. Recent research: primary care

- General Practice and NHI
  - Benefits to income and practice of GPs
  - Public/private mix - capitation constraints vs. commercial incentives
    - 'class discrimination was formally built into the provision of medical treatment' (Digby)
  - Geography of general practice
- Public opinion
  - Survey of 1942 popular dissatisfaction
- Demographic momentum
  - Rising rate of sickness claims / prevalence of morbidity friendly society records
  - Reflects population ageing

Digby 1999, Loudon, Horder, Webster, 1998; Powell 2005; Harris 1992; Riley 1997; Harris, Hinde, Gorsky 2006, 2011

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Voluntary hospitals: distribution, provision and utilisation

- **Uneven geography of provision and utilisation**
  - The 'caprice of charity'
  - But overall growth and slow narrowing of spatial variation
  - For some probability of obtaining voluntary hospital treatment a function of residence

- **Did municipal hospitals compensate for voluntary insufficiency ?**
  - Voluntary: positive correlation to wealth, negative correlation to need
  - Municipal: positive correlation to need, and in the cities negative correlation to wealth
  - Taken together insufficiency diminishes, but municipal side under-resourced

Hollingsworths 1985 Powell 1992; Gorsky, Mohan, Powell 1999; Mohan 2003, 2006, unpublished

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Voluntary hospitals: financial failure?

- Partial failure confirmed
  - Current account deficits:
    - 1933 24% - 1939 37% London, North West, teaching hospitals
  - Capital accounts
    - Some with crisis of reserves, but no national picture
- From charity to group prepayment ?
  - Growth of mass contributory schemes (10m covered 1939)
    - Payroll deduction, parallels NHI

Cherry 1992, 1997; Gorsky, Mohan, Powell 2002; Gorsky, Mohan, Willis 2006; Mohan 2006; Doyle 2007, 2010

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Local government health spending: growth, democracy, unevenness

- Capacity *partially* determined by local wealth base *BUT*
  - Overall interwar growth of sector
    - Local taxes, user fees and central grants
  - Diversity partly reflects local preferences
- Poor law/public assistance medicine not growing
  - 'chronic cases were increasingly left behind' (Levene) [demographic momentum]
  - but no national picture

Preston 1985; Lee 1988; Marks 1996; Powell 1997; Welshman 2000; Willis 2001; Levene, Powell, Stewart 2004, 2005, 2006; Levene 2009; Gorsky 2011

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Integration: how much joint working?

- Public / voluntary
  - Some effective co-operation
    - Urban hospitals councils: 'techno-scientific networks'
  - Some friction and competition
- Public / public
  - Variability of public health/poor law co-operation: 'progressive' vs traditional

Rivett 1988; Pickstone 1985; Sturdy 1992; Doyle 2007, 2010; Gorsky 2004; Gorsky, Mohan, Willis 2007; Neville 2012

Case studies: London, Manchester, Sheffield, Middlesborough, Sheffield, Leeds, Birmingham, Bristol, Plymouth, Exeter, Aberdeen, Gloucester.

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Labour mobilisation?

- Conflict, not consensus
  - Progressive alliance of labour movement and Fabian bureaucrats
- Labour and health: against the mixed economy
  - Socialist Medical Association
  - Municipal socialism
  - Hospital contributory schemes – high participation, but hostility /apathy during pluralist negotiation
- Labour divided
  - TUC vs. Labour Party – expand NHI vs. municipalisation
  - Variable local sentiment
    - **EITHER** hostility/ apathy **OR** support/ relaxed towards diversity
    - Depending on: labour market, industrial structure, unionisation, prosperity, size/ power of middle class

Webster 1990; Stewart 1997, 1999; Willis 2001; Powell 1995; Gorsky, Mohan, Willis 2005; Earwicker 1982; Doyle 2010, Neville 2012

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Citizenship and public opinion

- Interpreting mass voluntary hospital support
  - Active citizenship/ survival of civic engagement / 'popular' charity?
  - Was this instrumental / pragmatic ?
    - signifies willingness to pay
    - transferable to state system
- Uncovering public opinion
  - Higher levels of support for voluntary system
  - Beveridge-era hostility anomalous

Finlayson 1993; Daunton 1996; Gorsky, Mohan, Willis 2006; Doyle 2007, Gosling 2011; Hayes 2012, forthcoming

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Conclusions: time for a new synthesis?

- *Performance* of mixed system – *probably no*:
  - Affirms and clarifies failures of
    - public/private mix in NHI, voluntary /localist insufficiencies and inequities
    - though nuanced and variable
- Understanding *political context* of *transition* from diversity – *probably yes ... but*:

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The UK 'big bang' in comparative context

More conflictual: Progressive/Labour

Growing consent for public role: 'devolved centrism'

Institutional context :

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Demographic momentum

Reform era 1938-1945:

Pluralism/interest politics OR state autonomous actor

Labour apathy

Fox 1985, Jacobs 1992, Hacker 1998, Tuohy 1999

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