

# Partisan Strategy at the Post-War Emergence of the British and Swedish Health Systems

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## Abstract

A simplistic analysis of Swedish and British politics in the aftermath of the Second World War could lead to a belief that the Swedish welfare state would develop in a more statist, bureaucratised way than its British counterpart. The logic being that Social Democratic hegemony in Sweden should be contrasted with regular periods in office for the British Conservative Party. This paper provides theory and evidence that suggests such an analysis is misleading. Following strategic calculations as to the likely durability of the redistributive aspects of the welfare state in each country, the Swedish Social Democrats were able to pursue a welfare state programme of a far less rigidly statist nature. By contrast, the British Labour Party, fearing future Conservative rule, were constrained to pursue more traditional 'nationalised' welfare state structures. The consequence was far more effective redistribution of income in Sweden than the UK.

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[Britain's National Health Service] was the first health system in any Western society to offer free medical care to the entire population. It was, furthermore, the first comprehensive system to be based not on the insurance principle, with entitlement following contributions, but on the national provision of services available to everyone. It thus offered free and universal entitlement to State-provided medical care. At the time of its creation it was a unique example of the collectivist provision of health care in a market society. It was destined to remain so for almost two decades after its birth when Sweden, a country usually considered as a pioneer in the provision of welfare, caught up. (Klein, 1989, 1)

## 1 Introduction

A simplistic analysis of Swedish and British politics in the aftermath of the Second World War could lead to a belief that the Swedish welfare state would develop in a more statist, bureaucratised way than its British counterpart. Such a view would be based on the logic that Social Democratic hegemony in Sweden should be contrasted with regular periods in office for the British Conservative Party. Thus, while the Left dominated in Sweden and was able to build a welfare state upon this political foundation, in the UK the electoral fortunes of the Left were markedly worse. Labour endured repeated long periods in opposition — a role that afforded them very little influence over policy due to the prevailing archetypal majoritarian parliamentary system. In this view, the greater (Swedish) left-wing strength should be associated with more 'leftist' health policies than were implemented in the UK. In turn, the typical view of 'leftist' involves ideas of larger state control, bureaucratisation, and socialisation.

The ensuing text provides theory and evidence showing that such an analysis is misleading. Following strategic calculations as to the likely durability of the redistributive aspects of the welfare state in each country, the Swedish Social Democrats were able to pursue a welfare state programme of a far less rigidly statist nature. By contrast, the British Labour Party, fearing future Conservative rule, were constrained to pursue more traditional 'nationalised' welfare state structures. The consequence was far more effective redistribution of income in Sweden than the UK.

I begin by setting out the theoretical case regarding the differing strategic positions faced by each left-wing party, respectively. I then move to a justification of the selection of the UK and Swedish health systems as the two cases under study. From there, the following two sections provide theoretically motivated histories of the development of the UK and Swedish health systems, respectively. The final section draws the discussion together and provides a concluding overview.

## 2 Theory

In this paper, I take as my theoretical core the idea that (left-wing) parties will adjust their policies based on whether they are likely to *win* future elections and whether they are likely to have veto power even if they *lose*. Furthermore, that redistributive policies can usefully be divided into cash transfers and public services, the latter of which are far more difficult to cut as they embody large amounts of highly-organised labour with a direct interest in defending against spending cuts.<sup>1</sup>

In that light, the expectation is that where left-wing parties do not expect to win future elections or to have veto power against proposals by future right-wing governments, they will seek to structure health systems in particular ways. Those include limiting the cash component of the system and maximising the organisation and influence of medical unions.

To this point, the theory advanced in this paper is the same as that presented in my welfare retrenchment paper, albeit with a different empirical application. However, the close comparative analysis undertaken below allows for the development of the theory regarding the distinction between cash transfers and public services even further. I do so in two ways that relate to how political parties interact with public opinion.

First, I claim that where the principle that services are provided free at the point of use is strongly embedded within the institutional and political context, cuts in those services are likely to be felt more strongly by the public than would cuts in an equivalent system structured as cash transfers. The reason being that the effect of cuts in cash transfers can be spread across the entire budget of each individual while cuts in a public service, which tend not to allow for the possibility of top-up with extra cash payments, must be borne entirely in consumption of that service. As such, members of the public will notice service cuts to a greater extent and, therefore, be more likely to reject them. A consequence of this dynamic is that establishing a principle that services are free at the point of use is a useful strategy for making it more difficult for a subsequent government to reduce expenditure on those services.

The second link to public opinion revolves around the extent of policy discretion and, therefore, agency available to partisan politicians in the presence of the vote-seeking need to converge on the preferences of the median voter (Downs, 1957). On large and important policy issues, the question becomes: how specific are the preferences of the median voter? Parties can obviously only converge to those preferences to the extent that they are defined. I claim that it is reasonable to consider that the preferences of the median voter are likely to leave a fairly large degree of policy discretion open to parties. The vagueness of these preferences could stem from rational ignorance over the implications of policies, perhaps manifesting itself in ‘satisficing’ behaviour (Simon, 1955) in which voters set a minimum level of payoff that they expect or require from a policy. Even where the preferences are widely recognised

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<sup>1</sup>See accompanying papers from this project at <http://tim.hicks.me.uk/research/> for further details.

as being in favour of a large scale increase in public provision for a particular policy area, the specifics of how this should be implemented are unlikely to form part of the median voter requirement.

It is the discretion that this affords parties in the structuring of policies that I claim to be an important and unacknowledged aspect of the standard theory partisanship. The importance stems from the idea that the power to shape the structural form of a policy area in the present amounts to the power to shape the *future* politics in that area. If the median voter would be satisfied with a policy structured as either cash transfers *or* public services, then a politician with less on-going commitment to the scheme would be wise to choose the cash transfers option. Similarly, a politician with a strong commitment to the scheme and who fears an ‘uncommitted’ politician is likely to be elected in the future would be wise to choose the public services option.

This paper makes an empirical contribution supporting a further theoretical advance. Scholars from the historical institutionalist school working on issues surrounding welfare states have emphasised the importance of historically contingent, path dependent, processes of development (Pierson, 1994; Hacker, 1998; Thelen, 1999; Peters, Pierre and King, 2005). In doing so, they have also highlighted how ‘critical junctures’ at particular points in time where a policy area can be thought to have reached a crossroads are important to study (Thelen, 1999; Capoccia and Kelemen, 2007).

My theoretical claim relates to this notion of critical juncture, but grafts onto it the sort of strategic, calculated, decision-making by political actors that is more usually associated with so-called rational choice institutionalists (c.f. Hall and Taylor, 1996). I take the historical institutionalist claims more seriously than most have so far been willing to themselves. That is, if path dependence is such a powerful force in politics, then we should expect political actors to take advantage of that process, where desirable, at the critical junctures that afford them some policy discretion to do so. A rational actor, understanding the importance of path dependence, will use it to embed their preferred policy outcomes. A position of this sort seems in accordance with the push from Peters, Pierre and King (2005, 1284) to produce a “clearly identified source of agency” when explaining political change.

### 3 Case Selection

#### 3.1 Countries

The selection of Sweden and the UK as the two comparative case studies is made for a number of reasons. First, and most obviously, my theoretical claim concerns how left-wing parties will choose to structure the welfare state when they are in power. My historical focus is on the build-up of welfare states that occurred after the Second World War. While

there were important developments in welfare states before this point,<sup>2</sup> the post-war period is conventionally recognised as being a crucial time that saw radical advances in state-sponsored welfare provision across many ‘developed democracies’. The selection of this period also has the advantage that, in the aftermath of the War, the political environment in most countries potentially relevant to this study was fairly settled — and unconditionally democratic. Hecló (1974, 15) saw similar reasons for his own comparison of Swedish and UK social policy — as well as the fact that both countries were seen as early leaders in this field.<sup>3</sup>

Given the theoretical position of this paper, one requirement is that the two selected cases experienced left-wing government at this point. The transition from broad-based war-time coalition government to left-wing rule in both countries thus fulfills this requirement — and also excludes several other prominent candidate cases, such as France, West Germany, and Italy.

The influence of the Second World War provides a further reason to compare Sweden and the UK: neither experienced all-out war on their own territory. The consequence being that both emerged *relatively* better off in terms of housing and industrial capacity, as compared to other continental European countries. That Sweden remained neutral during the war and Britain emerged as a victor also removes any complicating factor associated with political vacuums following shifts to democratic post-war regimes.

There is, of course, a positive reason to choose to compare these two countries, as well. While they offer the similarities described above, they also differ in respects that are most relevant to the theoretical claims that I am seeking to test. The Labour Party in the UK and the Swedish Social Democrats (SAP) were faced with fundamentally different institutional and electoral prospects; differences which, I will claim, led them to pursue rather different structures of welfare state.

First, the electoral system in Sweden amounted to proportional representation (PR) while that in the UK was the archetypal first-past-the-post (FPTP) majoritarian system. Recent theory has suggested that PR systematically favours left-wing parties while FPTP favours right-wing parties (Iversen and Soskice, 2006; Ticchi and Vindigni, 2005). Even if we assume that the benefits of hindsight were not available to parties in the 1940s and 1950s so that they were not aware of the theoretical bases for such a bias, the distinction between PR and FPTP remains relevant. The essence of majoritarian systems is that they give an extra boost to the largest party (or parties) in the translation of votes to seats so as to yield stronger, more cohesive, often single-party, governments. For this reason, if nothing else, a left-wing party operating in a FPTP environment would have had good reason to expect future governments to be formed by right-wing parties with fairly high probability. The simple swing of the

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<sup>2</sup>See, for example, Bunbury (1957) on the British National Insurance Act 1911 or Baldwin (1990) for a broader comparative view, as well as the references in *Sections 4.1* and *5.1*, below.

<sup>3</sup>Unfortunately, Hecló did not include health care in his study.

pendulum, even if it is a fair one, being enough to give fairly unconstrained power to the Right. By contrast, PR systems do not have this inherent tendency to boost the power of the largest party. The effect being to promote a more consensual politics as single-party majorities are less likely (Lijphart, 1999).

Second, and related to the differing electoral systems in operation, the SAP faced a right-wing bloc divided between the Liberals, the Conservatives, and the Agrarians while the Labour Party faced a united right-wing party in the British Conservatives. This fact made the SAP easily the largest political party in Sweden, gaining around twice as many votes as its nearest competitor in elections of the period. As such, if the need were to arise in the future for coalition government in Sweden, there would be more opportunities for the SAP to forge a parliamentary alliance, and thus attain power, than for other parties. Indeed, the SAP took advantage of these circumstances in allying with the Agrarians in 1936.

Third, following the much-remarked Saltsjöbaden agreement of 1938 between organised capital and labour, the Left had an accepted, institutionalised, extra-parliamentary arena through which they could pursue their interests (Lewin, 1994). That is, even were the SAP to lose power in parliament, the strength of the labour movement and its position of accord with the major business organisations was such that they could have reasonable beliefs about being able to defend their core interests against right-wing governmental attack. By contrast, no such corporatist agreement and unified labour movement was available to the Labour Party.

My claim, then, is that when the SAP and Labour Party found themselves in power in 1945 they faced fundamentally different strategic positions. The Labour Party could look forward to the prospect of unconstrained Conservative rule in the not-too-distant future. The SAP, on the other hand, could reasonably expect to form more governments than its right-wing opposition and anyway had far less to fear from an incumbent right-wing government, should it come to pass.

One further factor also suggests Sweden as a particularly appropriate case study. The constitutional reforms it underwent between 1969 and 1971 changed the strategic position in which the SAP found itself. The reform actually moved the SAP's position to be somewhat more similar to that of the Labour Party. As such, that reform offers an extra opportunity to observe whether differing strategic positions of the sort discussed above lead to differing policy choices on the part of the Left.

## **3.2 Policy Area**

With the motivation for the case selection set out, a further question remains: which aspect of the nascent welfare states to focus on? Some of the more prominent components of what is generally accepted as the welfare state provide little scope for analysis as there is little

possibility for them to be supplied as publicly provided services rather than cash transfers. Unemployment benefits and pensions fall into this category.

Education is one possibility but it is often not thought to be a core component of a welfare state. Further, while having undeniable redistributive potential, calculations as to the egalitarian effect (or otherwise) of such a publicly provided or funded service is likely to be somewhat different to that of the more standard welfare state activities due to the large lead-time before such effects can be realised. That is, creating and investing in a profoundly egalitarian education system that equalises either opportunities or outcomes of 5 year-olds from the opposite ends of the socio-economic ladder will have little notable payoff until those 5-year-olds leave the education system at the age of 18 or 19. A 13 year wait for even *initial* payoffs, is surely rather a different prospect to instant results from other kinds of welfare state investment. To be clear, I certainly do not claim that parties will have no care for education policy. Rather, education would seem to be a less clear-cut policy area with which to test my theoretical claims.

The most obvious remaining area of welfare state activity is, then, that of health care. Expenditure on health care forms a very large portion of public expenditure both in the immediate post-war period and, even more so, in the present day. As such, it is clearly of high political significance, if only because of its sheer size. In contrast to education expenditure, it is clear that results from investment in health care are likely to be felt fairly instantaneously in that people will immediately reap the benefits of greater access to medical staff, medicines, equipment, and the like. It is also clear that health care has the capacity to be highly redistributive. Finally, the realities of various existing health systems around the world make it obvious that the provision and funding of health care can take very different forms — with government-provided free-at-the-point-of-use services at one end of the spectrum, and fee-for-service cash-based systems (often coupled with forms of insurance) at the other. Thus, the analysis of the structure of national health care systems fits the requirement that left-wing parties had some discretion over the systems that they employed.

## 4 The Founding of the British National Health Service

Although the National Health Service is sometimes portrayed as if it sprang fully armed from the forehead of Aneurin Bevan, its form owed a great deal to the nature of health care before 1939. But there was nothing predetermined about the form it took. Many possible models were under discussion in the pre-war period. (Glennester, 1995, 45)

The founding of the National Health Service (NHS) in Britain is a seminal moment in

British politics. While health care had been developing for many years,<sup>4</sup> Day and Klein (1992) term the years around 1945 as a period of “constitutional politics” in health policy as compared to a more normal consensual climate at other times.<sup>5</sup> Similarly, in discussing health policy, Hacker (1998, 93) writes that, “If any moment in modern British politics deserves to be called a critical juncture, it is the Labour landslide of 1945”.

In the aftermath of the Second World War, health policy reached a point from which any of a number of courses could have been pursued. The question here is why a particular course was chosen. In order to answer that, it is necessary to provide a little historical context. The next two sections provide this. From that base, I analyse the final adoption of the reforms that constructed the NHS.

Fundamentally, my claim is that the Labour Party, and Aneurin Bevan in particular, acted strategically by constructing a system that would come to be extremely difficult to dismantle or adjust for any subsequent Conservative governments. Nationalisation of the hospitals, a strong commitment to care being free at the point of use, and a (partially thwarted) move towards a medical profession that would come to be largely dependent on the decisions of government for their financial security led to a pattern of popular and particular interests that made the NHS the enduring national institution that it quickly became.

The argument advanced below is somewhat unconventional in that it rejects the notion of cross-party ‘consensus’ over the adoption of the NHS and instead sets out an explicitly partisan analysis of the process of health reform. I claim that the perception of war-time consensus is mistaken, showing that this view is an artifact of the pressures of coalition government and the public support for the Beveridge Report. In essence, the Conservatives were forced to accept development of a new health system by the pressure of the median voter, while Labour were out front leading the charge. Furthermore, while the popular view was that *something* must be done, there was, nonetheless, considerable discretion over the structure of the health system that would be built. Bevan’s bold departure from the war-time plans is evidence, in itself, of this fact. Thus, had the Conservatives won the election of 1945, it is reasonable to expect that they would have designed rather a different institution.

#### 4.1 The Pre-Second World War Legacy

In the UK, the pre-war pattern of health care had been shaped to a large degree by the National Health Insurance Act 1911. As noted by Eckstein (1959, 19),

At the end of the Second World War, some 24,000,000 people — roughly half the British population — were covered by compulsory health insurance.

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<sup>4</sup>Abel-Smith (1964) provides a history of ‘The Hospitals’ from 1800 and Bunbury (1957) sets out great detail on the passage of the National Insurance Act 1911.

<sup>5</sup>Day and Klein (1992) also see constitutional restructuring in 1911 and 1989, but these are not directly relevant to our discussion here.

A feature of the system, and one much noted by Eckstein (1959, 22), was that its administration was split in two. Medical benefits were administered by local Insurance Committees composed of doctors, pharmacists, and representatives of local government. Cash benefits<sup>6</sup> were administered by Approved Societies, which were essentially private, albeit notionally non-profit, health insurers.

While obviously a step in the direction of ensuring universal health care coverage, the 1911 Act fell far short of that mark. The system, enacted by the Liberal government under the auspices of Lloyd George at the Treasury, provided for compulsory health insurance for only the *working* sections of the *working* class. The self-employed (e.g. small traders) and the unemployed dependents of workers did not benefit from the scheme, with the consequence that large sections of society were excluded from health coverage (Eckstein, 1959, 20; Lindsey, 1962, 8).

Even those insured under the scheme only had access to general practitioners (GPs), rather than hospital specialists. Indeed, Lindsey (1962, 13) considered this to be “[c]ertainly the most deplorable aspect of the Health Insurance”. With the growing complexity of medicine and the high workloads of GPs, it became increasingly difficult for them to keep pace with medical advances. Thus, the benefits of new specialist health care were an even more remote possibility for those without the income or wealth to purchase it.

On top of exclusion of half the population, from an egalitarian point of view, the National Health Insurance scheme suffered from another fatal problem — at least as perceived from the political realities of the 1940s. Effectively, it provided what, in modern parlance, might be termed a ‘two tier’ service. While there was a set of “basic” services guaranteed to all insured under the scheme,<sup>7</sup> the more extensive raft of services provided for by the Act were made optional, dependent upon the financial position of the individual Approved Societies (Lindsey, 1962, 12). Such arrangements may have been justifiable on budgetary principles and the political realities facing Lloyd George when passing the Act in 1911,<sup>8</sup> but it had noted distributive effects due to a related provision of the Act. That provision being that each Approved Society was free to turn away those that they considered to be “bad risks” — those likely to impose heavy costs in the future (Eckstein, 1959, 28). Of course, such bad risks were highly correlated with the kinds of industrial employment that large portions of the burgeoning working class was engaged in. The effect, then, was to allow the better off — both financially and in health terms — to self-select into separate insurance pools. As insurance premiums were fixed by the Act but the risk pool associated with different Approved Societies varied dramatically, the financial position of the Societies also varied accordingly.

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<sup>6</sup>I.e. ‘sickness benefits’, more of which, below.

<sup>7</sup>Including “exceedingly low cash payments during illness” (Eckstein, 1959, 20).

<sup>8</sup>See Bunbury (1957) for a detailed, insider’s, view of the formulation and passage of the 1911 Act. It provides a rare view of the nitty gritty of public policy making — one that is sorely missed for the period under study in this paper.

So, therefore, did the provision of the optional extended portions health insurance. In Aneurin Bevan's words,

The result was that these Approved Societies were compelled to curtail benefits to their members, while other societies with a different industrial composition were able to distribute the full benefits. That situation consequently helped the strong and hurt the weak. (Bevan, 1952, 78)

Overlaid above the system of (sometimes insured) GP care was a rather decentralised, uncoordinated, hospital system. This was split into two sectors, the 'voluntary hospitals' and the 'municipal hospitals'. These latter institutions were owned and run by local governments and many of them had emerged out of the old Poor Law workhouses; local governments taking-over these Victorian vestiges that housed the elderly and infirm, often in Dickensian conditions. Despite having somewhat more beds than the voluntary hospitals,

A large proportion of public beds were occupied by the aged, infirm, and chronically ill — especially by mental patients — so that a bare count of beds is scarcely indicative of the relative importance of the two systems. (Eckstein, 1959, 35)

The voluntary hospitals, then, formed the basis for the provision of the truly specialist care available in Britain at the time (Eckstein, 1959, 35). These were charitable institutions, but of widely differing characters. The most prominent were the 'great teaching hospitals', preponderantly found in London, but the spread of all voluntary hospitals, if not leading specialists, was rather more even across the country.

Municipal hospitals were legally obliged to treat (to the extent that they could) any patient that presented themselves, while voluntary hospitals were not. However, as Eckstein (1959, Chapter 2) is at pains to emphasise, access to the services of voluntary hospitals was far from out of reach of the poor — assuming that they actually lived near such an institution. The finances of voluntary hospitals were such that relatively high fees for the wealthy were used to subsidise services to the poor. However, with the passage of time, their financial status became more and more precarious. The percentage of revenues derived from patient fees and "insurance sources grew steadily larger during the later history of the voluntary system, the hospitals continued to be heavily dependent on gifts and donations to make ends meet" (Eckstein, 1959, 36). Nonetheless,

by the late 1930s many of the voluntary hospitals, which accounted for about one-third of the beds, were in deep financial trouble. Even the great teaching hospitals endlessly teetered on the edge of bankruptcy. (Timmins, 2001, 104)

One final aspect of the pre-reform hospital services is relevant. The outbreak of the Second World War brought into sharp focus the perilous financial position of the hospitals as

their services were suddenly in huge demand. A large infusion of state funding was provided to plug the holes in a move that Lindsey (1962, 19) terms ‘temporary nationalisation’. This was the Emergency Hospital Scheme. The new funds bought extra beds and extensions of specialist services. On the shaky foundations of the pre-war system, a temporary wartime service was constructed. It was not, by design, built to last. Nor did it.

## 4.2 Wartime Planning

The aim of this section is to show that the perception of cross-party consensus regarding health reform during the war is, in fact, mistaken. To that end, I present evidence that the Conservatives were far from in agreement with their Labour coalition partners on the appropriate way forward. Instead, they sought to hold off and water down reform plans. Contrary to those who argue that the broader period was noteworthy for its consensus, the analysis here shows that partisanship *did* play a role in the politics of the NHS.

Perhaps surprisingly, given the size of the challenge facing the country in fighting a ‘total war’, the wartime period was one of major governmental planning initiatives in the social policy realm. Of course, the most prominent example of this process is the much-heralded Beveridge Report of 1942 (Beveridge, 1942). The report was wide-ranging, but Baldwin (1990, 117) notes that a “National Health Service (NHS) and universal family allowances were assumptions of his recommendations”. Further,

Beveridge’s scheme was characterized by four attributes and two attempts to avoid their worst consequences. Benefits were to be universal, flat-rate, subsistence and not conditional on need. An examination in that order is as good as any. (Baldwin, 1990, 117)

‘Assumption B’ of the Beveridge Report was that the system of social security would be built upon the foundation of “a national health service for prevention and for cure of disease and disability by medical treatment” (Beveridge, 1942, 158). Further,

a health service providing full preventive and curative treatment of every kind to every citizen without exceptions, without remuneration limit and without economic barrier at any point to delay recourse to it, is the ideal plan. It is proposed accordingly that, in the contributions suggested as part of the Plan for Social Security, there shall be included a payment in virtue of which every citizen will be able to obtain whatever treatment his case requires, at home or in an institution, medical, dental or subsidiary, without treatment charge. (Beveridge, 1942, 162)

So it was that William Beveridge placed a health service free-at-the-point-of-use firmly on the political agenda. While he deemed that the actual structure of the service to implement

his prescribed principles to “fall outside the scope of the Report” (Beveridge, 1942, 159), his outline, owing to its ensuing public support, partially constrained the options available for policy-makers.

The Ministry of Health had been internally discussing possible structures for a future national health service. Numerous options had been presented, including extension of the prevailing insurance system, enhancement of the municipal hospital system, and outright nationalisation of the hospital sector (Timmins, 2001, 109). Spurred into action by the Beveridge Report — and its rapturous reception — the ‘irresistible pressure’<sup>9</sup> in favour of implementation of the Beveridge recommendations led Churchill to sanction a more detailed process of planning for a new health system in 1943.

The incumbent Health Minister at the time was the National Liberal, Ernest Brown.<sup>10</sup> He was, however, replaced within a few months by, the Conservative, Henry Willink. It was Willink who produced the white paper entitled ‘A National Health Service’ in February 1944.

Its opening statements were both noble and crystal clear: that everybody ‘irrespective of means, age, sex, or occupation shall have equal opportunity to benefit from the best and most up-to-date medical and allied services available’; that the service should be ‘comprehensive’ for all who wanted it; that it should be ‘free of charge’, and that it should promote good health ‘rather than only the treatment of bad’. (Timmins, 2001, 111)

On the face of it, Timmins’ conclusion of the situation following publication of the White Paper was reasonable.<sup>11</sup>

It was now certain that a National Health Service, largely tax-financed, free at the point of use, and comprehensive, covering family doctors, dentists, hospital services and more, would arrive. Its precise form, however, remained far from clear. (Timmins, 2001, 111)

This implied view of consensus is, though, a little too neat (Jefferys, 1987; Powell, 1994).<sup>12</sup> While Willink’s White Paper appears to share much in common with the subsequent reform enacted under a Labour government — see below — there were numerous differences between the two, mostly revolving around what must surely be seen as deficiencies with the White Paper proposals. These deficiencies are fairly well accepted as stemming from Willink’s reticence in challenging the various interest groups related to health reform. The result was

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<sup>9</sup>To paraphrase Timmins (2001, 110).

<sup>10</sup>This was, of course, during the period of wartime coalition government.

<sup>11</sup>Hacker (1998, 68) subscribes to a similar view in dismissing the relevance of partisanship in the subsequent passage of the NHS Act (see *Section 4.3*).

<sup>12</sup>See also Hickson (2004) for a critique of the view that a ‘postwar consensus’ emerged.

a proposed system that would surely have failed to fulfill the expansive goals that it set for itself. While apparently similar to the subsequently constructed NHS, the system proposed in February 1944 was in fact rather a different beast.

An important question must be answered at this point, however. If the Conservatives published a health system proposal that was fundamentally egalitarian and redistributive in principle and indeed structured in a broadly similar way, does that not undercut the argument that the subsequent design of the NHS by the Labour Government was a profoundly partisan act? The answer is ‘no’ for at least four reasons.

First, the war-time government was a *coalition* government, which makes it somewhat more difficult to ascribe agency to the Conservatives for the plans that were published. Despite the presence of a Conservative Minister of Health, there was a large amount of policy bargaining going on within the government. Klein (1989) describes that,

the White Paper was an attempt to reconcile the views of the principal coalition partners: the Conservative and Labour parties. When the Prime Minister, Winston Churchill, had last-minute qualms about publishing the White Paper, he got a sharp reminder about the political realities from Lord Woolton, the Minister for Reconstruction. (Klein, 1989, 11)

Second, and this speaks to the “political realities” stressed by Lord Woolton, public opinion was now emphatically on the side of the proposals contained in the Beveridge Report — especially those relating to health care. A contemporary opinion poll by the British Institute of Public Opinion found that 88 percent of the population thought that “it is a good plan to include doctors’ and hospital services for the entire family” in the post-war social policy settlement (Durant, 1942, 13). Furthermore, the poll revealed that “[t]he astonishing figure of 95 per cent [...] showed some knowledge of the Report two weeks after publication” (Durant, 1942, 5). This figure accords with the number of copies of the Report sold by Her Majesty’s Stationery Office exceeding 600,000 (Timmins, 2001, 23). Truly a remarkable amount given the length, complexity, and dryness of the publication. Interestingly, Addison (1993, 71–72) asserts that it was the very reticence of Churchill to engage with post-war social policy issues that made it possible for Beveridge to fill the resulting “policy vacuum”. Hardly an account of Conservative agency.

Third, having opened a Pandora’s box by allowing Beveridge to publish his report, the Conservative response seems to have been one of procrastination. Their hope was that the wave of popular support for the more radical aspects of social reform would wane in time for the coming election.

Churchill felt that there was little need for a declaration on domestic reform. The Tory party, he reflected, was ‘the strength of the country: few things needed to be changed quickly and drastically (Addison, 1993, 71)

When this tactic appeared to be failing — in the face of persistent public support for reform backed up by growing agitation from the Labour Party, both inside and outside the government — grudging acceptance of compromise became the fallback position. Powell studies the Parliamentary debate on the White Paper and finds “that for many Labour Members it represented a minimum on which to build for the future, while for many Conservatives it represented the limit to which they were prepared to go.” (Powell, 1994, 337). That the Willink White Paper was riddled with compromises unwanted by the Conservatives became clear as soon as the coalition dissolved. In the brief spell of the caretaker government before the general election, Willink quickly dropped several aspects of ‘his’ previous proposal, including: the Central Medical Board to employ all doctors; the removal of Insurance Committees as the organising unit for GPs; government power over the geographic distribution of GPs; the removal of local authority control of hospitals (Klein, 1989, 15–16); and any “salaried element” for doctors’ pay (Klein, 1989, 23).<sup>13</sup> On the eve of an election — one in which the Labour Party was making great play of their social policies — one must suspect that Willink and the Conservatives felt constrained from going any further than this.

Fourth, as we shall see, when the Conservatives actually had the chance to vote for a version of the National Health Service that was rather similar to that proposed in the Willink White Paper, they repeatedly voted against it. Indeed, they did so both at second and third readings — the former being a parliamentary convention implying that the party was against the bill *in principle*, not just on grounds of implementation detail.

The consensus on consensus, as it were, must, therefore, be questioned. Klein (1989) claims that,

Nothing is more remarkable than the shared assumption that the health service should be both free and comprehensive [...]. (Klein, 1989, 26)

The evidence suggests, however, that the ‘consensus’ was, at best, one of passive and reluctant acceptance on the part of the Conservatives. Furthermore, even if one accepts this best case of Conservative support, Klein’s warning is pertinent.

Accepting a general notion is, of course, one thing. Devising and implementing a specific plan is, however, a very different matter. (Klein, 1989, 7)

The subsequent passage of the National Health Service Act makes this even more plain.

### 4.3 The National Health Service Act 1946

The NHS came into existence in an atmosphere of conflict. This conflict was generated by the strong ideological commitment of the post-Second World War Labour

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<sup>13</sup>Even while defending the notion of ‘consensus’ during the period, Lowe (1990, 164) writes that the White Paper “proved to be little more than a discussion paper which the Conservatives [...] soon sought to modify”.

Government, and the opposition of the Conservative Party and some sections of the medical profession, to what was perceived as a thoroughly socialist aspiration; a health service, universally available, comprehensive, centrally-planned and free at the time of need. (Carrier and Kendall, 1998, 82)

With the votes finally counted on July 26th, 1945, the Labour Party was returned to government with a landslide parliamentary majority. The victory was a shock to the Conservatives who had assumed that the leadership of the war hero, Churchill, would see them to victory. Furthermore, the scale of the victory coupled with Labour's strong campaigning on welfare issues gave the incoming government a strong mandate to construct what would become the modern British welfare state.

In this heady atmosphere, Clement Attlee, the new Prime Minister, appointed the first Labour cabinet to be backed by a Labour parliamentary majority. In a bold move, his choice as Minister of Health was the "maverick" left-winger, Aneurin ('Nye') Bevan (Webster, 1991, 4). Bevan's ideology had been forged in the mining industry of the South Wales valleys, his political career built in the union movement, and he had earned a reputation for outspoken dissent, even within his own party. In that light, making Bevan his youngest cabinet minister and charging him with both construction of a national health system and resolution of the chronic housing shortage<sup>14</sup> was no run-of-the-mill appointment by Attlee (Webster, 1991, 3).<sup>15</sup>

Of course, the appointment of Bevan was not a *complete* surprise. In 1943, he had made a name for himself by leading left-wing parliamentary opposition to certain health care reforms under discussion by the wartime coalition government. Furthermore, Webster (1988, 76) expresses the view that the appointment was "shrewd" as "[a] leader of backbench revolt was removed and submitted to Cabinet discipline".<sup>16</sup> Bevan came to office under no illusions that the prevailing system of health care was sufficient for the needs of the nation — and least of all for the needs of the Labour constituency. In short order, he set about constructing a new system that would sit "in place of fear" for *all* British people.

Two aspects of the process of health reform in the immediate post-war period have been much noted by historians of the process. First, Bevan's decision to 'nationalise' the voluntary hospitals. Second, the "battle" between Bevan and the British Medical Association (BMA) over the degree of autonomy that individual doctors would have under the scheme. Both are notable in the context of the theoretical position of this paper.

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<sup>14</sup>The Ministry of Health had responsibility for Housing, as well.

<sup>15</sup>That Bevan was a controversial figure is not in doubt. Churchill had referred to him as a "squalid nuisance" (Webster, 1991, 3) while, on his own benches, "[w]ith Attlee, Bevan and Morrison, Bevan had, at one time or another, fought bitter, rasping, near-mortal duels" (Foot, 1973, 25).

<sup>16</sup>In fact, Webster (1988, 76) goes further, referring to the Ministry of Health as "an obvious political graveyard".

### 4.3.1 Hospital Nationalisation

The nationalisation of voluntary hospitals was remarkable on two counts: the size of the programme and the relative ease with which it was achieved. While the nationalisation was a large break with previous health policy in the UK,<sup>17</sup> Bevan's desire to pursue it should hardly be surprising.

Timmins (2001, 104) emphasises the perilous state of hospital finances and, indeed, notes that at least one voluntary hospital leader had predicted nationalisation as far back as 1930.<sup>18</sup> He also quotes a discussion between Bevan and Lord Moran,<sup>19</sup> then President of the Royal College of Physicians, in which Moran is seen to lead Bevan to the conclusion that nationalisation is the only way to achieve a more equal geographic distribution of the benefits of specialist medical care. The problem, as Bevan saw it, being that the extant provision was overly centered around the large urban areas — most especially London and its teaching hospitals. In fact, the distribution of general practitioners was also far from ideal.<sup>20</sup> Nevertheless, Webster (1991, 6) is more reticent in assigning the reasons for Bevan's nationalisation drive, writing that, “The source of Bevan's inspiration on hospital nationalisation is not entirely clear”.

Notwithstanding the claim by Eckstein (1959, Chapter 2) of a bias in favour of the working class in the voluntary hospital system, there seems little doubt that the dual problems of impending insolvency and an unequal distribution of specialist resources confronted Bevan in 1945. Nonetheless, such difficulties, by themselves, need not necessarily have led to nationalisation as the logical response. An insurance-based system, subsidised by the state, could have solved both issues, as well as satisfying the BMA Klein (1989, 5) — and, as we shall see, was the option chosen by the SAP in Sweden.<sup>21</sup> With such a policy, the financial issue would be resolved via an infusion of public funds that would ultimately, if somewhat indirectly, have flowed to the cash-strapped hospitals. The geographic issue would have been resolved via the effective provision of medical purchasing power across the full breadth of the country. Why, then, with various political groups arrayed against it and with a widely accepted alternative system available, is it “evident that this opportunity [for nationalisation] was grasped with

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<sup>17</sup>Indeed, Timmins (2001, 113), perhaps over-stating the case, asserts it was “the biggest break with all that had gone before”.

<sup>18</sup>Lindsey (1962, 14–15) reports that voluntary hospital finances were found to be precarious as early as 1921, when Parliament voted to distribute funds with which to keep them afloat. Again, in 1925, a call for funds was made, with the Parliamentary response being to pass a law enabling local government to subsidise the voluntary hospitals, at their discretion.

<sup>19</sup>Related by Lord Moran to Michael Foot.

<sup>20</sup>Lindsey (1962, 7) found that by “the late 1930's there were [...] one-half as many doctors per capita in South Wales as in London, and only one-fourth as many per capita in the industrial midlands as in the coastal resort city of Bournemouth”. This gives the lie to the claim made by Eckstein (1959, Chapter 2) that the pre-war health system was notably pro-poor.

<sup>21</sup>Klein (1989, 5) notes that the insurance-based system was “the road followed by nearly all other Western societies in the post-war period, and advocated by the BMA not only in the 1930s but also subsequently”.

alacrity” with Bevan making “this radical policy initiative the central feature of Labour’s NHS legislation” (Webster, 1991, 6)?

An obvious answer is that, in nationalisation, Bevan saw the opportunity to embed his health reforms in a far more permanent way. Strategic thinking of this sort was certainly on his mind. He dismissed insurance- and employment-based alternatives for national health care as the political dynamic inherent to each would create interests that were antithetical to the sort of egalitarian system that sought. Of those two alternatives, he wrote that,

A whole network of strong points emerge, each with a vested interest in preventing a rational national scheme from being created. Thus to the property Lobby is added the Lobby of those who stand to lose under the national project. In the end they may have to be bought out at great cost in time, effort and money (Bevan, 1952, 78–79).

By contrast, under the nationalised system that he proposed, the direct dependence of the hospitals on the state linked hospital staff’s interests with the size of the government’s financial contribution. The design also created an in-built redistributive mechanism of funds being drawn from the proceeds of general taxation. Both aspects were of crucial importance as they would prove to be effective buttresses against most subsequent attempts at retrenchment and all could have been seen as such by Bevan in 1946.

### 4.3.2 Conflict with the Doctors

The position of the doctors had always been of major importance in the development of health policies — especially through the war period. With the passing of the National Health Service Act 1946, in terms of political discourse at least, this would become even more true. Indeed, Glennerster (1995, 51) terms this period of conflict between Bevan and the British Medical Association (BMA) as the “battle for the NHS”.

Numerous other researchers have written extensively on this aspect of the politics surrounding the formation of the NHS and there is little need to recapitulate the intricacies of the saga.<sup>22</sup> Instead, the aim here is to show that the conflict with Bevan *did* force a concession out of him that is of significance to the theory set out in this paper: a commitment *not* to create a nationwide salaried civil service of doctors, but rather to leave them, effectively, as independent contractors.

While the BMA certainly had specific policy disagreements, the first sign of trouble was Bevan’s decision to eschew the consensus-building process of professional consultation throughout the policy-making process. Instead, he chose to write the Bill *first*, noting that,

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<sup>22</sup>The interested reader is directed towards Webster (1988, 107–120), Timmins (2001, Chapter 6), and (Lindsey, 1962, Chapter 3).

I do not propose, nor would time allow, to embark upon any long series of negotiations before the Bill is settled. (Bevan writing in a Cabinet Memorandum; reproduced in Webster, 1991, 43)

Following Bevan's relatively dismissive, high-handed, approach to the BMA, its leadership, in the form of Guy Dain and Charles Hill — the latter of which would find himself as a Conservative Cabinet minister in the 1950s — was emphatic in its response to the Act. Where the Government finally sought negotiations on implementation details, the BMA remained intent on fighting previous battles, with the ultimate goal being the passage of amending legislation. In the face of Bevan's perceived intransigence, the BMA position "rapidly escalated into fanatical opposition" with the Minister denounced as, among other things, a "medical Führer" (Webster, 1991, 8).

At root, the BMA's main objection was the prospect of the medical profession becoming subsumed within the general civil service, with all the limitations on their freedom that that implied. In fact, they had good reason to fear such an outcome. In the planning phase for the NHS Bill, Bevan had, "circulated [Cabinet] memoranda [that] were vague about the method of remuneration of general practitioners, but [... he] confided to colleagues that he wanted to move 'eventually to a full-time salaried service' " (Webster, 1991, 7).

Whether Bevan's Cabinet confidences were breached or not, his ultimate aims were certainly exposed by the BMA and their Conservative parliamentary defenders. On this point, it is worth quoting Webster's account of the Second Reading of the NHS Bill extensively.

The debate followed predictable lines. Conservatives complained most about the nationalisation of voluntary hospitals, which was regarded as a gratuitous assault on charitable institutions. Willink made capital out of Labour Ministers' statements in favour of voluntary hospitals during their previous incarnation in the Coalition Government. Conservatives were also suspicious of Labour's intention to relegate the issue of doctors' salaries to regulations, which they exposed as a subterfuge for introducing a full-time salaried service. On the Labour side, Bevan came under criticism for not committing himself to full-time salaried service and for permitting pay beds in state hospitals. (Webster, 1988, 98)

Bevan, then, took flak from both sides on the issue of a salaried medical profession. In that light, his decision to kick the issue into the long grass of (negotiated) regulations rather than come to a firm decision in primary legislation was probably the best course open. The Bill had provision for some basic salaried component, with the remainder being made up of payments based on the number of patients registered with each doctor — capitation. Thus, it appears that Bevan had largely reconciled himself to defeat on this point even at the Second Reading stage.

Some of my hon. Friends on this side of the House are in favour of a full salaried service. I am not. I do not believe that the medical profession is ripe for it, and I cannot dispense with the principle that the payment of a doctor must in some degree be a reward for zeal, and there must be some degree of punishment for lack of it. (From Bevan's speech during the Second Reading debate, reproduced in Webster, 1991, 72)

Despite this apparent dismissal of the notion of a salaried profession, the reference to the doctors not being "ripe for it" is revealing of his true preference. As Webster (1991, 72) makes clear in a footnote to the passage quoted above, Bevan subsequently and controversially qualified his Commons statement by saying, "There is all the difference in the world between plucking a fruit when it is ripe and plucking it when it is green". Bevan's true preference seems in little doubt, then. Rather, he recognised the need for compromise in the face of overwhelming professional opposition and hoped to be able to pursue his goal at a later date.

The obvious question is why Bevan (and much of the rest of the Labour Party) would have a preference for a salaried medical profession employed on similar terms to the existing civil service? Again, an obvious answer is that such a system would have dramatically reduced the likelihood of doctors, under a future Conservative government, successfully agitating to reduce the redistributive effects of the NHS. While an outright prohibition of private practice by NHS-affiliated doctors would have been the strongest move, the imposition of a salaried employment relationship between doctors and the State would have reduced the prevalence of for-pay medical services. That was an outcome that was deemed highly desirable by Labour due to (legitimate) fears that fee-for-service medicine would be detrimental to the health of the poor as they would be less likely to have sufficient funds to pay for it. Instigating a civil service medical profession would, therefore, have been an extra step towards the goal of locking-in free-at-the-point-of-use medical services that were in no way restricted based on ability to pay. Salaried doctors would be placed in a position in which their interests would, in all probability, be aligned with those of the poorer NHS users. Attempts to cut NHS resources in the form of doctors' salaries — and thus attempts to reduce this aspect of the level of service — would be defended vigorously by the powerful, organised, doctors.

In this light, it is little wonder that Webster (1988, 97) termed "acceptance that the time was not ripe for introduction of full-time salaried service" as "Bevan's major concession to the profession". With the 'Appointed Day' for the commencement of the new health service rapidly approaching and the doctors still in open revolt and threatening non-cooperation with the new scheme that would effectively have wrecked it, Bevan agreed to the passage of amending legislation that explicitly ruled out imposition of a salaried profession.

## 4.4 The Fight Over Charges

In what may appear counterintuitive at first glance, in this section, I show that the fight over the introduction of NHS charges that played out *within the Labour Cabinet* actually provides evidence as to their partisan importance. While Bevan was pressed by several of his own colleagues to accept charges, this was in a context of dire economic circumstances and was resisted with all the power that he had. Furthermore, when charges were finally introduced by Labour, they were very small compared to those employed both by subsequent Conservative governments and, particularly, left-wing governments in Sweden.

As has already been noted, the NHS was constructed with the principle of free-at-the-point-of-use at its foundation. However, it would not take long for this tenet to come under strain, even with the stewardship of the NHS still under Labour and Bevan. After a year of operation, it became clear that the cost of the service was considerably higher than initial estimates had suggested. With budgetary pressures mounting amidst a prevailing national economic context that remained seriously weakened by the recent war, the Government began to seek ways of containing costs across the board. The NHS was not immune to the budgetary pressure.<sup>23</sup> Indeed, its spiraling costs well above initial estimates suggested that cuts were possible in health as spending appeared to be rather out of control. For the first nine months of operation from July 1948, gross spending ran at around 140 percent of its projected level. The pattern was similar for the full year 1949/50.<sup>24</sup>

Despite heavy pressure from Stafford Cripps, the Chancellor of the Exchequer, in a letter to Cripps, Bevan largely resisted attempts to limit health expenditure by the Exchequer. Most relevantly to the discussion here, Webster writes:

Firmly precluding the introduction of charges [... Bevan] declared ‘I just say at once that I am entirely opposed to any idea of obtaining additional appropriations in aid by requiring payments from the beneficiaries under the service’. Bevan defended this conclusion at length, pointing out that the yield from charges would be insignificant compared with the extent of administrative inconvenience. Furthermore, charges would involve a premature and fundamental reversal of policy, raising the spectre of the means test and harking back to the discredited Poor Law. (Webster, 1988, 138)

Webster (1988, 139) continues,

Coming at the outset of the long argument over the imposition of charges in the NHS, this letter provides a useful reminder of Bevan’s depth of feeling on this

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<sup>23</sup>See Webster (1988, Chapter 5) for a more detailed discussion of this period.

<sup>24</sup>Figures taken from Webster (1988, Table I, 135).

issue, and an indication of his grounds for attaching great symbolic importance to the principle of a service free from direct charges.

Quite so.

Bevan's defense against Cripps would ultimately fail, however; budgetary imperatives came to outweigh the Welshman's political and rhetorical manoeuvres. Cripps' continuing pressure forced Bevan into compromise. He was offered a choice of charges for in-patients, dentures, or spectacles, or an increase in the rate of National Insurance (NI) contributions that would be siphoned to the NHS (Webster, 1988, 143). With the use of NI contributions (later) deemed to be "a form of poll tax with all its disagreeable features" (Bevan, 1952, 79) — not least a reduction in the redistributive character of the welfare state — Bevan faced a dilemma. Interestingly, his initial reaction was to propose, as an alternative, a reduction in the level of NI benefits — that is, a reduction of cash transfers in favour of (health) services. This was not accepted. With his back to the wall, he finally relented, agreeing to the imposition of a charge for all prescriptions below the level of one shilling. The estimated saving was £10 million, out of a total NHS budget of around £450 million — i.e. approximately 2 percent of total health expenditure. Webster (1988, 143) describes this as Bevan's "momentary capitulation".

The capitulation really would prove to be momentary. Although Parliamentary approval was obtained,<sup>25</sup> no progress was actually made with the implementation of prescription charges. Difficulties over which, if any, categories of people should be entitled to exemption from the charges, over how to physically collect the cash, and a shrewd game played by Bevan saw deferral of the scheme. By the time it was even nearly ready for adoption, Bevan successfully argued that to do so at a time so close to the impending general election was politically unwise (Webster, 1988, 147). The issue of NHS expenditure and, therefore, of charges, would not disappear, though.

The election of 1950 returned Labour to power, but this time with a dramatically reduced majority of six. This new political reality meant no possible respite for Bevan and the NHS. Cripps quickly retired, only to be replaced by the equally implacable Hugh Gaitskell as Chancellor. With NHS spending continuing to rise, a Cabinet committee was convened to oversee the issue — a committee which would increasingly force Bevan onto the defensive. Still, he held out against the imposition of charges to the health system. By February 1951, Attlee moved him to the Ministry of Labour.<sup>26</sup> The switch, however, would not dim his passion for defence of the health service he had constructed.

Matters came to a head at a Cabinet meeting on April 9th 1951. Gaitskell had managed to wring the concession of ophthalmic and dental charges from the new Minister of Health, Hilary Marquand. It was felt that these were more politically expedient due to the public

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<sup>25</sup>Via the NHS (Amendment) Act 1949.

<sup>26</sup>With a promise "to protect the social services from further cuts" from Attlee, according to Webster (1988, 166).

perception of “abuses” in these areas (Webster, 1988, 173).<sup>27</sup> Nonetheless, Bevan remained resolutely against the move, making it clear that he would resign if his Cabinet colleagues agreed to force through the measure. In this threat, he was joined by the then President of the Board of Trade and future Prime Minister, Harold Wilson. Gaitskell had made the issue one of confidence in his tenure as Chancellor and it appears that Attlee felt compelled offer support to him (Webster, 1988, 172 and 177). Notwithstanding several grave misgivings as to the wisdom of forcing resignations, the rest of the Cabinet fell in with the two senior members. Bevan and Wilson resigned.

Bevan’s resignation speech to the House of Commons is instructive as to his thought processes. The Conservative threat clearly loomed large.

I have been accused of having agreed to a charge on prescriptions. That shows the danger of compromise. Because if it is pleaded against me that I agreed to the modification of the Health Service, then what will be pleaded against my right hon. Friends next year, and indeed what answer will they have if the vandals opposite come in? What answer? The Health Service will be like Lavinia — all the limbs cut off and eventually her tongue cut out, too. (Reproduced in Webster, 1991, 192)

#### 4.5 The Conservative NHS

The election of October 1951<sup>28</sup> saw the Conservative “vandals” returned to power. The swing was small — indeed Labour actually obtained a plurality of *votes* — but Churchill had the support of a majority of 17 in the Commons. Perhaps signifying relative priorities, the Ministry of Health “became very much a second-tier department” (Timmins, 2001, 203), with its Minister no longer being entitled to attend Cabinet. However, after a short initial spell, a rising star in the form of Iain Macleod was appointed to steer the NHS.

It is worth highlighting just what the theoretical account offered in this paper would lead us to expect as to the development of the health system under the Conservatives. As the representatives of the higher-earning sections of society — those effectively subsidising the health care of the poorer through their taxes — we would expect them to be relatively more concerned to limit the financial input to the Service by the Exchequer. As Labour had shown — albeit to a limited extent — charges were one way of doing this. The use of National Insurance contributions — which had more of the character of flat rate payments for each individual — to fund the NHS would also reduce the redistributive effect. However, the theory also suggests that the Conservatives would have notable difficulty in making many large cuts, particularly in the realm of medical wages — be they doctors’ or otherwise.

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<sup>27</sup>Dentists and opticians were in a role of prescribing the use of ‘appliances’ and then directly profiting from their manufacture and/or sale — a fairly clear conflict of interest.

<sup>28</sup>Called at Attlee’s discretion, in search of a larger majority.

And so it came to pass.

Faced with similar budgetary constraints as those confronted by the previous Labour government, the new Conservative Chancellor, Rab Butler, immediately set about searching for savings from the Ministry of Health. Numerous charges and cuts in service were proposed, although political realities stymied all but the introduction of prescription charges. An examination was made of the possibility to introduce ‘hotel charges’ for hospital beds, but it was felt that the “political price would have been high” (Timmins, 2001, 204). The Conservatives had only a small majority, and that was contingent on support from the National Liberals. While Timmins (2001, 204) writes that the “charges raised little”, at their peak of 5.6 percent of the NHS budget, they were still notably above that proposed under Labour. The enduring support for the NHS, however, provided limited room for manoeuvre for the Conservatives in the area of charges — at least initially. By 1960, nine years into continuous Conservative rule, the now infamous Enoch Powell had managed to raise the proportion of NHS funds stemming from NI contributions and charges to 22 percent, with the consequent reduction in redistributive effect (Timmins, 2001, 209).<sup>29</sup>

Meanwhile, the NHS wage bill grew hugely in the mid 1950s. A pay arbitration process entered into by the previous Labour government and the GPs went dramatically in favour of the latter. The arbitrator, Mr Justice Danckwerts, sided fully with the BMA and awarded the GPs an increase five times the size offered by the Government — together with back-pay. Similar claims from hospital doctors and others ensued (Timmins, 2001, 205). The power of organised labour, albeit of a largely middle class ilk, played its first role in ensuring public expenditure to the health service continued to increase.

In the light of all these events, it is surely right to qualify the extent to which a bipartisan consensus existed regarding the NHS. Broad support was indeed in place for a national service supported by the State — even with a portion of redistributive tax financing. However, ultimately there was no such consensus as to the imposition of charges — with Labour supporting them only grudgingly, at great political cost, and in a time-limited fashion. Another factor also seems clear. The structure of the NHS constructed by Bevan almost certainly served as a great political constraint on the desires of the subsequent Conservative government. Popular support for their newly-acquired benefits prevented much in the way of charges. Organised labour, amongst other things, ensured that spending would go on rising.

Nonetheless, at the end of 13 years of Conservative rule, the redistributive capacity of the system had been chipped away to a noticeable extent. Borrowing the assessment of (the Conservative) Lord Fraser, Raison (1990, 15) seems apposite in describing Labour and Conservative policy as being on “parallel lines but always heading for very different destinations”. One of Bevan’s great achievements was to keep those lines parallel a little longer than might

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<sup>29</sup>Infamous, that is, for his so-called ‘rivers of blood’ speech on the perceived perils of immigration, not for his transmutation of the NHS.

otherwise have been the case.

## 5 The Evolution of the Swedish National Health System

The story of Swedish health care really is one of evolution. In several respects, it can be contrasted with the more big bang reforms undertaken in the UK in the period 1946–1948. The question is why this should be so. In order to answer that, I begin with a brief outline of the system that came to be in place at the end of the Second World War. The subsequent story of reforms, failed and realised, provides a telling contrast to contemporaneous developments in the UK.

### 5.1 The Pre-Second World War Legacy

The early foundations of the Swedish health system were laid in the late 19th century under the influence of welfare developments in Germany (Ito, 1980, 44). In 1891, voluntary health insurance legislation was adopted with minimal state funding support. Indeed, until 1910, state funding would constitute less than 10 percent of funding (Ito, 1980, 59). These two features — voluntarism and low state funding — combined to produce relatively low levels of insurance coverage across the population well into the post Second World War period. Ito (1980, 44) shows a fairly stable upward trend from 0 percent of the population covered in 1895 to only around 15 percent covered in 1930.

During this early period, the sickness funds that administered the health system actually had a strong tendency to employ cash payments rather than in-kind services as their mode of operation (Immergut, 1992, 195). Indeed,

The series of Swedish sickness funds laws between 1891 and 1931 can be characterised more accurately as income maintenance insurance in case of illness than as health insurance, since few medical benefits in kind were provided. (Ito, 1980, 53)

This pattern began to change with the passage of the Sickness Funds Law in 1931.<sup>30</sup> As Lewin (1988, XXX) describes, the law came at the end of a rather unstable parliamentary period in Sweden during which minority government was the norm.<sup>31</sup> Consequently, it is somewhat difficult to ascribe particular partisan motives to the law, despite the presence of a liberal Prime Minister, Carl Gustaf Ekman.

More clear is the effect of the law. One of the fundamental changes it created was a requirement for the sickness funds to place a greater emphasis on benefits in kind. Slow

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<sup>30</sup>Immergut (1992, 197–202) provides a more detailed description of the adoption of this law.

<sup>31</sup>See Janson (1928) for a fairly detailed description of the coalitional dynamics of the period.

implementation of its provisions impeded developments but the proportion of cash benefits, as opposed to in kind benefits, dropped from 80 percent in 1931 to 64.9 percent in 1938 (Ito, 1980, 54). The other notable aspect of the 1931 reforms was that it heralded a far larger state contribution to the finances of the sickness funds. In the decade following adoption of the law, the state's contribution approximately doubled, from 15 percent to 30 percent (Ito, 1980, 62).

Voluntarism, however, remained. The organisation of the system was also rather “haphazard”, leaving some areas without coverage from a local fund (Immergut, 1992, 195). So, while the proportion of the population with health insurance began to rise more quickly,<sup>32</sup> inevitably, a huge majority of the population remained outside the organised insurance system.<sup>33</sup>

At the end of the war, this was essentially the prevailing pattern of health care coverage in Sweden.

## 5.2 The Immediate Post-War Period

The immediate post-war period saw the solidifying of political dominance by the Social Democrats. The 1944 election gave them a majority in the First Chamber and an effective majority in the Second Chamber when the Communists were accounted for (Lewin, 1988, 180). The party system remained in their favour, with the Agrarians potentially available as coalition partners should the need arise and the rest of the non-socialist bloc still split between Liberals and Conservatives. They had held power from 1932 until the outbreak of war, and then as the lead faction of the war-time coalition government. While broad differences remained between the socialist and non-socialist blocs in parliament as to the degree to which the state should intervene in the economy, the 1948 election was to prove that this skirmishing would not be to the detriment of the Social Democrats (Lewin, 1988, 187). Political hegemony was theirs and, accordingly, they started to plan for the long term (Lewin, 1988, 168).<sup>34</sup>

With the Saltsjöbaden corporatist agreement in place, the purely economic realm appeared to be largely settled (Swenson, 1991*a,b*; Lewin, 1994). The Social Democrats turned their attention to construction of what would emerge into the archetypal welfare state. Interestingly, Baldwin (1990, 135) suggests that, in the ensuing “triumph of egalitarian universalism [...] [h]ealth insurance played an important role [...], but pensions came foremost”. In

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<sup>32</sup>As a result of the more attractive terms created by the greater state contribution.

<sup>33</sup>Immergut provides slightly different figures to those of Ito (1980, 48), on which I base my ‘huge majority’ statement. Immergut (1992, 201) states that from 1930 to 1940 there was “a shift from 20 percent of the adult population (persons over 15 years of age) to 48 percent”. It is not clear if Ito's figures include those under the age of 16, but that seems likely to explain the discrepancy. Still, the fact remains that a huge proportion of the population fell outside the health insurance system.

<sup>34</sup>Indeed, King and Rothstein (1993, 161) assert that this long term planning began as early as 1936 when they “could expect to dominate government for several years”.

itself, this is indicative evidence in favour of the position taken in this paper regarding relative preferences over cash and in-kind redistribution. The details of developments in health care reinforce the point.

### 5.2.1 The Höjer Non-Reforms

As *Section 5.1* made clear, health care in Sweden was far from universal and the Social Democrats were not slow to attempt to reform the system so as to expand coverage. The first attempt to do so was to find patronage in the form of J. Axel Höjer, Director of the National Board of Health. In the ‘strong state’ tradition highlighted by Lindvall and Rothstein (2006), the Government had appointed him in 1943 to chair a commission to investigate how best to pursue a reorganisation and expansion of the health system (Immergut, 1992, 205). After extensive research, including analysis of the British NHS developments, he presented his report in 1948.<sup>35</sup>

In sum, the Höjer report was a proposal for a national health service, a national health service whose ambitions surpassed those of the NHS. Not only would hospital inpatient care be delivered at virtually no cost, but all forms of outpatient care — whether taking place in doctors’ private offices, in the government offices of public doctors, or in the hospital outpatient clinics — were to be integrated into this service. Private patients and private fees — something that all Swedish doctors, both hospital and office-based, private or public, depended on — would be eliminated; all doctors would eventually be paid a government salary. (Immergut, 1992, 205–206)

Of course, the doctors did not have to wait for publication of the report to know of its contents. Several members of the committee were their own. As early as 1946, Dag Knutson, the incoming chairman of the Swedish Medical Association (SMA), had clashed in a public debate with Höjer over “whether doctors should continue to be members of a free profession or should become health care civil servants” (Ito, 1980, 63). However, upon publication, the report provoked a huge controversy.<sup>36</sup> In a remarkable, albeit reversed, parallel with the rhetoric employed in the clash between Bevan and the BMA, Höjer denounced Knutson as “pro-Nazi” (Heidenheimer, 1980, 206). Immergut (1992, 206) describes how the press sided on fairly predictable lines for and against the proposal, with the Conservative *Svenska Dagbladet* and Liberal *Dagen’s Nyheter* opposing and the Social Democratic *Morgontidningen* in support.

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<sup>35</sup>See Serner (1980, 101–102) for more details of the proposed reforms.

<sup>36</sup>Immergut (1992, 207) comments that “*Svenska Dagbladet’s* yearbook notes that no other legislative proposal received as much nor as critical press coverage in 1948”.

The Conservative Party itself, the Swedish Employers' Association, and even Landsorganisationen (LO) — the main trade union federation — were deeply concerned about the proposed health reforms. The latter's unease was primarily on grounds of cost, although there was also a desire that expenditure across the social services be correctly balanced (Immergut, 1992, 206–207). As if that opposition were not sufficient, the Federation of County Councils, headed by a Social Democrat, was strongly opposed. As owners of the existing hospitals, the councils feared that Höjer's reforms, by ousting private practice, would lead to staffing shortages as doctors fled the system (Immergut, 1992, 207).

In the face of this opposition, the Höjer reforms were axed. One interpretation of this result is that the SMA scored a victory against the governing Social Democrats. It seems incontrovertible that the SMA scored a victory against *Höjer*, but there are notable problems with calling the outcome a defeat for the Government.

There is a consensus that the SMA, both relative to its international cousins and in domestic terms, was a weak organisation. Both Ito (1980, 58) and Immergut (1992, 207) note that the number of doctors, per capita, in Sweden was remarkably low making the profession's economic and organisational capacity for applying political pressure correspondingly low. An obvious question, then, is how could such a weak grouping come to defeat a government with a firm legislative majority?

Ito's partial answer is that, faced with a reform that it found to be particularly threatening, the profession coalesced to an even greater extent and became stronger. From the election of Knutson as its leader,

Thenceforth, the SMA continued to become stronger, but never strong enough to defeat the public authorities. In some cases, it succeeded in postponement, but in the end it lost, and the state had almost full control of health insurance. (Ito, 1980, 63)

Even in Ito's terms, then, it is not possible to explain any putative SMA defeat of the government in terms of its own power. While the SMA became stronger, it never became "strong enough". Immergut implicitly acknowledges this difficulty, as well, writing that,

Whether the failure of the *Höjer* reform should be credited entirely to the lobbying campaign of the medical profession, however, is debatable. (Immergut, 1992, 208)

Her preferred explanation is that popular support for the welfare state in Sweden had eroded as the Social Democrats began to levy the taxes needed to pay for it. "Reactions to the Höjer reform fit very neatly into this general backlash against the welfare state" (Immergut, 1992, 208). But this interpretation is an awkward one for Immergut to make given her own theoretical stance on Sweden. Her claim is that the Swedish case amounts to

an example of “executive dominance”, whereby the executive was relatively unencumbered by political institutions that accorded interest groups the opportunity to exploit veto points. Her view is neatly summarised in the following passage.

For most of the period studied, the executive could count on stable parliamentary majorities bound by party discipline to ratify its proposals. Moreover, even at times when the majorities were unstable, institutional mechanisms developed to isolate policy-making procedures from both the executive and parliament allowed for continuous policy preparation despite fluctuations in the governing coalition. Paradoxically, institutional features introduced to preserve the power of the monarch and the Conservative Party during the transition to democracy ended up working to the benefit of the Social Democrats once they assumed control of the executive. Consequently, although these institutions were intended to ensure stability — that is, the status quo — they facilitated radical political change. This process was based on conciliation rather than conflict, however. (Immergut, 1992, 179)

In this light, Immergut’s recourse to the vagaries of public opinion around the 1948 election seems less credible — not least because that election saw the Social Democrats lose only 0.6 percent of their vote share and retain a majority in both legislative chambers (Immergut, 1992, 209).

A more natural interpretation, and one commensurate with the core of Immergut’s understanding of the Swedish case, is that the Social Democrats saw no need to pursue the Höjer reforms. Imposing salaried civil service status on the medical profession was not necessary. There was no need to co-opt the doctors into the defence of the health system under any future non-socialist government. Arranging finance such that health care became free-at-the-point-of-use — the over-riding principle that became a resignation issue for Bevan and Wilson in the UK — was also unnecessary. Maintaining the fee-for-use system kept the doctors contented whilst offering little downside to the Social Democrats as they were able to ensure that all of their citizens would have sufficient resources with which to pay for care. Indeed, Tilton (1990, 118) asserts that Gustav Möller, the *extremely* influential SAP minister in charge of social policy, got precisely the system that he wanted through the reforms that were subsequently implemented instead of the Höjer proposals.

The conclusion must be, then, that Höjer’s reforms were ultimately rejected because *nobody* particularly wanted them. In taking inspiration from the nascent British NHS, he had failed to take account of the political realities in Sweden. Despite this rejection, there remained a consensus within Sweden that reforms of *some* sort were needed so as to ensure that all sections of society had sufficient access to care. The prevailing voluntary system left too many on the outside.

### 5.2.2 The National Health Insurance Act 1953

By the time that the Swedish system took shape, it differed significantly from the British National Health Service that had been adopted a few years previously. The British program is primarily a medical scheme, while the Swedish system is primarily a form of social insurance designed to offset the consequences to living conditions of disease, disablement, or unemployment for medical reasons. (Board, 1970, 233)

Concurrent with the debate over the Höjer reforms, the Government had actually pressed on with legislative action to introduce provisions for compulsory health insurance. Indeed, the issue having been debated during the war, an Act to this effect was passed by Parliament in 1946. With the Act essentially an extension of the prevailing voluntary insurance system, and with doctors having been extensively consulted during the formation of its provisions, it passed without controversy (Blanpain, Delesie and Nys, 1978, 173). For financial and staffing reasons, operation of the Act was delayed until 1955 (Serner, 1980, 103) — a notable contrast with the urgency with which reform was pursued in Britain, which itself faced extreme financial difficulties following the war.<sup>37</sup>

In terms of characteristics, the compulsory insurance system finally implemented in 1955 was, unsurprisingly, rather different from the Höjer proposals; and, indeed, rather different from the British NHS. Compulsion was only applied to employees (Blanpain, Delesie and Nys, 1978, 172). A salaried medical profession was no part of the new system and fees-for-service remained at its core. Patients would consult with the same private doctors as before, only their new state-provided insurance policy would reimburse them for a proportion of the cost of doing so. The legislation did not impose a fixed tariff for consultations.

They were, however, regulated in the sense that the insurance provided reimbursement for 75 per cent of fees below a fixed level. The level served as a guideline, but physicians were not obliged to keep below it. (Serner, 1980, 103–104)

Even with doctors, of their own volition, holding their fees below the ‘fixed level’, the system was designed to pay a *maximum* of 75 percent of costs. How stark a contrast this is with the tooth-and-nail fight in Britain over the introduction of fees amounting to only 2 percent of health expenditure.

There were some similarities between the Swedish and British systems, however. Doctors were permitted to retain the use of private beds in the hospitals (that remained publicly-owned).<sup>38</sup> Somewhat in accord with the use of base-line salaries for doctors in the NHS, a

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<sup>37</sup>See Foot (1973, 50–59) for a discussion of the British financial predicament, together with Bevan’s views on the matter.

<sup>38</sup>This aspect was subsequently abolished in 1959 (Serner, 1980, 104).

low salary was provided to provincial doctors as a way of ensuring their financial viability. The quid pro quo being that they agree to treat low income patients. Even these consultations were on a fee-for-service basis, though, and the salaried doctors were free to undertake private practice, as well (Immergut, 1992, 210).

On top of the contrast between Britain and Sweden on the issue of fees-for-service, a further major differentiation can be drawn.

The important item was sickness compensation to cover loss of income [...] [T]he reader should keep this emphasis on sickness and disability compensation in mind. These items claim by far the greatest sums of money in the Swedish national health insurance system. (Serner, 1980, 103)

The quote from Board (1970) at the start of this section makes this clear in a comparative sense, as well. Figures from Kangas (2004, 196) provide some support for this comparative view, although the intervals at which data is available are not ideal for our purposes. In 1950, post-implementation of the Beveridge reforms and the NHS in Britain, but pre-implementation of the Swedish reforms of 1955, Britain and Sweden had approximately equal coverage and replacement rates for their sickness benefits. By 1970, the British coverage rate had actually dropped slightly while replacement rates had risen from around 50 percent to around 60 percent. In contrast, the Swedish coverage had remained at 100 percent and replacement rates had grown to nearly 90 percent.

### 5.3 The Late 1960s and Early 1970s

For 15 years, the reforms implemented in 1955 provided the core of Swedish health care. Some further tweaks were made<sup>39</sup> but the major features of the system remained in place until the so-called ‘Seven Crown Reforms’ in 1970. For the argument advanced in this paper, the reforms are significant. The main empirical point is that a health system reform that moved Sweden closer to the British NHS model was enacted precisely at the point when the governing Social Democrats had agreed to a batch of constitutional reforms that would leave them in a weaker position electorally, and with a body of institutions that offered less scope for them to veto changes to which they were averse when in opposition. My claim — and on this, I follow Immergut (1992, 222) — is that the Social Democrats responded to this change in their systematic strength by further embedding the Swedish health system in a structure that would allow it to weather any ensuing non-socialist government.

To make this case, I begin with an outline of the constitutional reforms that were enacted, together with a description of their subsequent effects. In the light of that discussion, I then move on to describe the pertinent details of the Seven Crown Reforms.

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<sup>39</sup>See, e.g., *footnote 38*.

### 5.3.1 The Constitutional Reforms

Immergut (2002) describes the main features of the constitutional reform. The electoral system (for the Second Chamber) was adjusted to make it more proportional, thus reducing some of the majoritarian bonus that was reaped by the largest parties — i.e. predominantly the Social Democrats.<sup>40</sup>

The First Chamber, which was indirectly elected by county council politicians was also abolished. As Immergut (1992, 238–242) stresses, this step was notably detrimental to the Social Democrats. The double disproportionality entailed by the indirect electoral system<sup>41</sup> meant that the Social Democrats had been able to secure a consistent absolute majority in the First Chamber from 1942 onwards. Furthermore, the eight year terms, as compared to three years in the Second Chamber, meant that there was a good degree of stability and the Social Democrats could rely on their strength for a fairly long period. That strength in the First Chamber was of real significance. While governments were notionally formed by majorities in the Second Chamber, the annual budget could only be passed by a joint sitting of both chambers and the Social Democrat strength in the First Chamber meant that they nearly always had that joint majority, even during their weaker periods in the Second Chamber. As such, they could nearly always veto budgets. Removal of the First Chamber, then, removed an in-built and stable mechanism of ensuring Social Democratic legislative strength. It also removed a veto point as all legislation previously had to be passed by both chambers. According to the veto player analysis of the sort advocated by Tsebelis (2002), this should tend to increase policy instability, and thus to increase the uncertainty of the Social Democrats over their ability to block future unwanted reforms.

Taking these reforms together, the simulation results presented by Immergut (2002) suggesting that the Social Democrats would have performed better electorally in the post-1970 period under the old constitution appear unsurprising. At the very least, the shift to unicameralism unarguably removed a veto point — and one that had been solidly Social Democratic — and thus increased the likelihood of future reforms being enacted by the non-socialist bloc.

How did the Social Democrats respond to this change? They instigated the ‘Seven Crowns Reform’.

### 5.3.2 The ‘Seven Crowns Reform’

The ‘Seven Crowns Reform’ earned its name from the principal change that lay at the heart of the package. Doctors would no longer be able to charge arbitrary fees for service. Instead,

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<sup>40</sup>Part of this reform would also expand membership of the Second Chamber. It now has 349 members representing 29 multi-member constituencies, with 39 top-up members used to ensure greater proportionality (Bergman, 2004, 205).

<sup>41</sup>I.e. an electoral bonus for the Social Democrats at the county level and then that bonus magnified by a further bonus in the actual election to the First Chamber.

a fixed tariff of seven crowns (*kronor*) would be charged for all visits, regardless of the services that were performed. This level of fee was decided upon after the government conducted a survey to find out the average cost of a visit to the doctor. The answer was found to be 70 crowns and the fee was set to 10 percent of this level (Blanpain, Delesie and Nys, 1978, 175). Thus, the cash component of health care was reduced by about 15 percentage points.<sup>42</sup>

The other main aspect of the reform, and one that clearly followed directly from the limitation on fees, was the move to a salaried medical profession. As Serner (1980, 104) notes, the change in the law “actually comprised a provision in the hospital law that forbade employees to accept any payment from patients”. No legal requirement was enacted to move doctors onto salaries, but in subsequent negotiations between the County Council Federation and the SMA, it was agreed that this was the most appropriate way forward.

It is interesting to note that “the Seven Crowns reform and the related negotiations introduced several of the more controversial points of the Höjer reform”. It was only the failure to find agreement on extension of the reform to private practitioners (outside of hospitals) that stopped the full Höjer package from being adopted in 1969 (Immergut, 1992, 214). Despite exclusion of the private doctors, “[o]vernicht, 90 percent of Sweden’s doctors became full-time salaried employees of the state” (Blanpain, Delesie and Nys, 1978, 175). In essence, then, the Seven Crowns Reform was a notable move in the direction of the British NHS model. Fees for service remained, but at markedly lower rates. The medical profession was finally a salaried civil service corps, with the resultant benefits from their bargaining strength as a way of maintaining wage levels in the public service. Indeed, Immergut notes this point, albeit in reverse.

There were advantages for the leadership [of the SMA] in accepting a salary form of payment. With an increased number of physicians, which not only weakened the market position of doctors but also brought in a large cohort of younger doctors, the leadership could improve the situation of its members more effectively by pursuing a hard line in salary negotiations than by clinging to private practice privileges. (Immergut, 1992, 215)

Doctors, then, had considerable capacity (and desire) to protect the health service in its new form. This fact must surely not have been lost on the Social Democrats, themselves.

In light of the evidence, Immergut’s summary of the political motivations underlying the Seven Crowns Reform seems apt.

The reform was part of a package of policies — in the areas of health care, taxation, and economic policy — that aimed to solidify the party’s electoral standing at

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<sup>42</sup>This is likely to be a low-side estimate as doctors were previously able to charge more than the notional tariffs for which reimbursement at the 75 percent rate was payable.

a time when it was at the peak of its power, but when its future control of the government was in jeopardy. (Immergut, 1992, 212)

## 6 Concluding Discussion

The historical accounts set out above fit rather well with the theory advanced in this paper. To make the case, a number of steps are required. First, that the British Labour Party and the Swedish Social Democrats faced very different strategic positions at the end of the Second World War with respect to their expectations over future right-wing policy influence. Second, that they recognised their strategic situations.<sup>43</sup> Third, that they were able to and did act upon the incentives provided by these different situations.

A fourth, but not necessary, step in the causal chain is recognition on the part of the actors that there were efficiency costs to structuring the NHS in its particular way. That being the case would provide further evidence that Bevan, the primary actor, was engaged in the construction of a second-best system, and so provide further indirect evidence that he was acting strategically.

In the event, it is surely uncontentious to say that Bevan *was* aware of the efficiency costs of his scheme. The Treasury considered that charges would be useful in providing an “education of the public who use the service” (Quoted in Webster, 1988, 143). Economic theory suggests that providing services at zero marginal cost<sup>44</sup> should lead to over-demand. Bevan’s own acceptance of this kind of logic has already been noted in the discussion above.<sup>45</sup>

A logical question to ask in the face of Bevan’s strategic policy-making is: did it work? That is, did he manage to construct a system that was relatively immune to the cost-cutting proclivities of ensuing Conservative governments? As shown in *Section 4.5*, the answer is again, ‘yes’. A large part of this flowed from the public support which the system created.

Created amidst controversy, the NHS was soon cocooned in consensus. Over the following decades, the NHS not only established itself as Britain’s most popular institution next to the monarchy — invariably receiving top ratings in all public opinion surveys — but increasingly came to be strongly supported by those who had fought its creation: the medical profession. (Day and Klein, 1992, 468)

So, not only did public opinion come to reinforce the system, but the doctors, who had fought bitterly against the scheme, came to be some of its most staunch defenders. Precisely as the theoretical account offered here would predict.

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<sup>43</sup>Although not necessarily how they differed from each other.

<sup>44</sup>Excluding time and travel expenses.

<sup>45</sup>See *footnote 27*.

Based on the first three causal steps in the argument, empirically, we should witness a rather different structure to and set of principles guiding the construction of the two respective health systems. This is unarguably the case.

The fundamental characteristics of the NHS, as constructed by the Labour Party, were: free-at-the-point-of-use, redistributive financing via general taxation, universal entitlement, and relatively small cash sickness benefits. By contrast, the fundamental characteristics of the Swedish system, as constructed by the Social Democrats, were: compulsory insurance-based, fee-for-service, cash payments with circa 75% reimbursement of fees, and relatively generous cash sickness benefits. Furthermore, at the point at which the Social Democrats came to face a political system that was notably less favourable to them, they reformed the health system in ways that reduced the fee-for-service component and further embedded the medical profession into a position that aligned their interests with those of the service users.

As to the second step of the causal chain, it is uncontentious to suggest that the Social Democrats recognised the enduring strength of their political position. This has most clearly been expressed with respect to the system of economic planning that they instituted, but it is hardly a stretch to think that this would have spilled over into other areas of policy. As Lewin (1988, 168) notes, “above all, the postwar program contained long-term plans”. On the British side, Bevan’s references to “vandals” and “vermin” with respect to the Conservatives and his expressed fear of what they would do if they came to power lend credence to the claim that he acted strategically, with a view to the future, in his construction of the NHS.

Underlying the claim here about differing preferences over the structure of national health systems is one of redistributive battles being fought between Left and Right. One objection to the position advanced by this paper may, then, be that health care is of little consequence in what has been termed the ‘strategy of equality’ (c.f. Le Grand, 1982). In his analysis, Eckstein (1959, Chapter 2) implicitly seems to subscribe to this view. Whether empirically accurate or not — and my position is certainly the latter — the relevant point is whether the principal policy actors saw the issue as one of redistributive consequence. In that light, Bevan’s statement to the House of Commons is instructive.

The redistributive aspect of the scheme was one which attracted me almost as much as the therapeutical. (Speech in the House of Commons in 1958 reproduced in Webster, 1991, 209)

This leads to, perhaps, the most contentious part of the argument here: that there was notable partisan agency on the part of Bevan in structuring the NHS as he did.

## 6.1 On the Partisanship of the NHS Act

As already indicated in *Section 4.2*, the prevailing view in the literature is that a cross-party consensus existed as to the necessity of reforming health care in Britain and that this found

expression in the 1944 White Paper that bears a striking resemblance to the subsequent NHS Act of 1946. In that light, the claim of partisan agency may appear unwarranted. However, a closer look at what this ‘consensus’ actually amounted to helps to *reinforce* the case for partisanship.

At root, the consensus had two broad components: that the pre-war system “was both inadequate and irrational” (Klein, 1989, 2–3). From this, scholars have gone on to argue that there was a kind of inevitability to the adoption of a reform like the NHS. Klein (1989, 5) argues that there were two possible responses to the inadequacy and irrationality of the prevailing system: universal health insurance and local public provision of services. As “Local government was already in the business of providing health care” (Klein, 1989, 6),

[t]o have adopted an insurance scheme would therefore have meant actively repudiating the service-based legacy of the past. (Klein, 1989, 6)

The problem with this line of argument is that Bevan *did* actively repudiate large features of the previous system — not least local government control of hospitals. Instead, he created centrally-controlled layers of regional administration that were specific to the health sector and expropriated large portions of the health care infrastructure owned and operated by local government. Thus, an argument of path dependence from local government control to the resulting NHS appears difficult to justify.

Hacker (1998) makes a similar claim as to the historical contingency of the NHS Act.<sup>46</sup> His argument is that the previous reforms — most notably the 1911 National Insurance reform — created a pattern of vested interests that inexorably led to the adoption of the NHS structure of health care in Britain (Hacker, 1998, 93). This leads him to conclude that,

In retrospect, what appears most striking about the events leading up to the establishment of the British National Health Service is their seeming inevitability. (Hacker, 1998, 84)

Again, though, this conclusion is rather puzzling. As already noted, there were a variety of possible reform schemes discussed inside and outside of government during the pre-war and wartime period. All faced problems — be they administrative or political — and the reform finally adopted was no exception. Furthermore, the electoral landslide won by Labour in 1945 provides telling evidence that the British people saw marked differences between Labour and the Conservatives. If they were ‘all the same’, why did *so many* voters reject the war hero, Churchill?

In fact, Labour campaigned heavily on social policy while the Conservatives down-played the issue. Indeed, they began engaging in a tactical retreat on the issue of health reform

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<sup>46</sup>As well as health care reform attempts in Canada and the USA.

even before the election was held. During the wartime coalition, the Conservatives had been consistently reticent in pursuing post-war social policy objectives and it was Churchill's view that nothing should be done until *after* the first post-war election. Issues of cost — i.e. the level of taxation on their constituency — loomed large for the Conservatives.

All this makes Hacker's conclusion as to the importance of the 1945 election all the more puzzling. He writes that,

The main impact of Labour's stunning victory did not, therefore, lie in the final structure of the NHS, but rather in the momentous political opportunity that Labour's triumph created. (Hacker, 1998, 94)

Either the "stunning victory" was important to health reform, or it was not. Hacker's position seems to be an uncomfortable one, on the fence.

My claim is that the "momentous political opportunity" afforded to the Labour Party was of critical importance. Had Churchill's Conservatives been returned to government in 1945, the passage of reform would, at the very least, have been notably slower. The kind of system proposed in the 1944 White Paper would have been trimmed and rationalised. The drop in public support for the welfare state as taxes (inevitably) rose would have been used as an excuse to rein in the earlier plans. Nationalisation of the voluntary hospitals would almost certainly not have occurred.

In short, the NHS is a very different institution as a result of being founded by a Labour Minister of Health rather than a Conservative. It is this different structure that has greatly contributed to the NHS being such an enduring welfare policy. For this, Aneurin Bevan must be held responsible. Importantly, though, had Bevan been operating in the Swedish political environment, he would surely have felt little need to construct the health care behemoth that he desired for Britain.

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