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Hospitals, Finance, and Health System Reform in Britain and the United States, c. 1910–1950: Historical Revisionism and Cross-National Comparison

Martin Gorsky

London School of Hygiene and Tropical Medicine

Abstract Comparative histories of health system development have been variously influenced by the theoretical approaches of historical institutionalism, political pluralism, and labor mobilization. Britain and the United States have figured significantly in this literature due to their very different trajectories. This article explores the implications of recent research on hospital history in the two countries for existing historiographies, particularly the coming of the National Health Service in Britain. It argues that the two hospital systems initially developed in broadly similar ways, despite the very different outcomes in the 1940s. Thus, applying the conceptual tools used to explain the U.S. trajectory can deepen appreciation of events in Britain. Attention focuses particularly on working-class hospital contributory schemes and their implications for finance, governance, and participation; these are then compared with Blue Cross and U.S. hospital prepayment. While acknowledging the importance of path dependence in shaping attitudes of British bureaucrats toward these schemes, analysis emphasizes their failure in pressure group politics, in contrast to the United States. In both countries labor was also crucial, in the United States sustaining employment-based prepayment and in Britain broadly supporting system reform.

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Introduction: Comparison in Health Systems History

The comparative history of health systems is now a substantial field, both in its own right and within the literature on welfare states. Britain and the United States have figured frequently in such histories, thanks to perceptions of them as “polar types,” the former with its early move to a centralized National Health Service (NHS) and the latter with its long-standing adherence to public-private welfare structures (Anderson 1963: 842). The two countries’ experiences have also been influential in shaping theoretical explanations of health system development. Put crudely, such approaches have moved on from an early focus on welfare policies as concomitants of industrial development or products of national political cultures. Instead scholarship over the last three decades has tended toward three strands of interpretation. Some have concentrated on the social forces that advance redistributive welfare reform, emphasizing either the agency of the organized working class or the decisive importance of cross-class solidarities. Others, thinking within a framework of political pluralism, have foregrounded the role of interest groups in determining the timing and extent of reform, with the medical profession typically the key actor. A third strand has privileged the nature of the state, emphasizing the role of bureaucracy as progenitor of change and the part played by institutional structures in advancing or impeding legislative development. Within this historical institutionalist school the concept of path dependence has gained particular traction, illuminating different national outcomes by showing how early decisions conditioned later trajectories.

These, then, are the main planks of interpretation with which new national or comparative research must engage. My aim here is to discuss the implications for such accounts of recent revisionist work on British and American health services in the first half of the twentieth century. Specifically, I focus on the financing and organization of hospital care in an era when both countries moved from traditional modes of philanthropy to new forms of organized prepayment. In Britain the period before the inception of the NHS had seen the introduction of statutory national health insurance (NHI) through which primary care was made available to employed workers. Hospital coverage, however, was excluded, and the response was the emergence of voluntary contributory schemes to provide access to the voluntary hospitals, the main sites of acute care. In the United States, meanwhile, legislators had decisively rejected European-style health insurance. An alternative route of private, employment-based

insurance had developed to provide income replacement during sickness, but in the interwar period this proved insufficient for hospital care. The U.S. solution was a different form of prepayment, notably Blue Cross.

Hitherto the similarities between these British and American funding models have gone largely unobserved, the national paths having apparently already diverged. Yet consideration of their parallel histories directs attention to common experiences. Their hospitals were tackling the challenges of broadening access and consolidating their financial base as medical technologies advanced. Both funding mechanisms had ramifications for hospital capacity and managerial control and for the regionalization of health systems. Both were responses by the private and voluntary sectors to earlier policy decisions to keep the state out of hospital insurance, setting a path creating new stakeholder interests that would shape subsequent debates. Both represented a means of providing health coverage for employed workers and hence are germane to discussion of labor's part in health system change. Yet both experienced different outcomes following the mid-century health care debates, with the U.S. prepayment funds retaining independence and the British contributory schemes losing their prime function to the NHS. Consideration of why this was so should therefore augment our understanding of this crucial phase of health politics.

Two preliminary points need to be made. First, this study does not propose a fundamental revision to the historical explanation of such changes, whose causes in both countries are multifaceted. Instead it asks how new research into hitherto underexplored aspects fits with existing theoretical accounts and, where it proves incompatible, what this suggests for readings of the politics of health reform. One place it leads is to a skeptical position toward any single "master explanation," whether treating interest group pressures as the primary factor, class and organized labor as the critical determinant, or the structural bias of institutions as crucial (Quadagno 2005: 11; Navarro 1989: 890; Steinmo and Watts 1995: 330). My case instead suggests that integrating insights from all three interpretative schools yields the most satisfying results.

Second, the primary research from which this article arose has been on the British side alone. It was animated originally by the aim of reevaluating earlier accounts of the voluntary hospitals and their role in the coming of the NHS. I subsequently developed the American comparison based on the secondary literature, both because the cross-national similarities noted above seemed worth exploring and because comparative approaches offered a means of averting "explanatory provincialism" and of gauging which causal factors were "decisive, as opposed to simply present" (Mar-

mor, Freeman, and Okma 2005: 339). My method here is therefore one of “confronting” two historiographies “with one another,” then identifying similarities and differences to prompt novel perspectives and questions (Hennock 2007: 4–5).

I begin with a brief outline of British and American health politics in the early to mid-twentieth century, then examine how these cases are treated by different analytical schools in cross-national comparison. I next introduce some of the recent literature on British and U.S. hospitals and health insurance during the interwar period and discuss its significance for the existing historiography. The central sections turn to the rise of the British contributory schemes and their role in hospital finance and organization. I compare this with hospital prepayment in the United States, particularly Blue Cross, where I argue that notwithstanding the different paths on which the two countries were set, some key similarities remained until the mid-1940s. Turning finally to the NHS debates, I draw on comparative analysis to examine anew the point at which the British path irrevocably diverged.

Trends in National and Cross-National Historiographies

Overview

Two periods of reform loom large in histories of health policy in Britain and United States: the 1910s, when the British government adopted a national health insurance (NHI) system and various American states rejected this option, and the late 1930s and 1940s, when Britain created its NHS and the United States again refused NHI. Before the 1910s health services in both countries were a mixed economy. Civil society organizations provided sickness insurance: the friendly societies in Britain and fraternities and industrial funds in the United States. Hospital provision spanned a public sector, which included mental asylums and poor law institutions (fewer in the United States), private proprietary hospitals (fewer in Britain), and acute care voluntary hospitals (Gosden 1961; Murray 2007; Peebles 1929: 9, 12; Pinker 1966: 49; Abel-Smith 1964; Rosenberg 1987; Jacobs 1992: 188). Policy debate followed the 1883 enactment of statutory sickness insurance in Bismarck’s Germany, which built on the work of existing sick funds (Hennock 2007). As its viability became established other countries followed, with Britain’s Liberal government initiating NHI in 1911 as part of a broader social program. It covered

specific categories of worker, with funding from employers, employees, and the state, to provide a sickness benefit and medical care, though not in hospitals; existing friendly societies and private insurers were the carriers (Harris 2004: 211–213). Gradually the population coverage of NHI extended, and many doctors combined insurance “panel” work with fee-paying private patients (Digby 1999). Meanwhile in the United States, Progressive reformers campaigned for the adoption of mandatory health insurance, but state legislatures rejected their proposals, as did a referendum held in California (Starr 1982; Hoffman 2001).

In both countries a new momentum for reform gathered from the 1930s, underpinned by concerns about service organization, finance, and population coverage. Although President Franklin D. Roosevelt decided against including health insurance within New Deal Social Security legislation, a series of attempts was made (generically, the Wagner-Murray-Dingell health bill) between 1939 and 1949 to legislate for NHI. None were carried, despite gaining presidential backing from Harry S. Truman in 1945, although federal aid for hospital construction was endorsed in the Hill-Burton Act of 1946. World War II and the reconstruction plans in the Beveridge Report catalyzed British interest in a comprehensive, universal, and free health service. The wartime coalition government initially proposed that this might be funded from a mix of NHI and general and local taxation (Beveridge 1942: 6, 160–161; Ministry of Health 1944). A lengthy phase of policy debate ensued, until the Labour Party won the 1945 election and the new minister of health, Aneurin Bevan, brought forward a bill. This unified the hospital service by bringing both voluntary and municipal institutions under central state ownership, funded principally through national taxation. Democratic accountability would be achieved through ministerial responsibility to Parliament. On this basis the NHS Acts for England and Wales (1946) and Scotland (1947) were passed, and the service was launched on the “appointed day,” July 5, 1948 (Klein 2006: 12–22; Webster 2002: 10–30).

Explanatory Approaches

Those are some basic facts of the two national histories. How are they accounted for in the broader comparative literature on welfare states and on health systems within them? Here I briefly sketch the current leading schools of thought and suggest how these have been applied to the British and American cases. Such a strategy inevitably oversimplifies: to allot particular explanatory models to given authors is not to imply dog-

matic theoretical attachment; typically it is a matter of emphasis within multilayered accounts. I also do not dwell on earlier theorists who have asked whether the development of welfare states is best understood as a “logic of industrialism” or a product of democratization, or as culturally determined (whether by national values or intellectual currents) (Skocpol and Amenta 1986: 131; Polanyi [1944] 2001: 152–162; Wilensky 1975; Ashford 1986). Each approach has its insights, but each has come to seem less compelling in the comparative historiography than accounts that in their various ways put “the state back in” (Skocpol 1985).

Writers with a Marxist perspective who treat the state as an arena of class struggle offer two broadly complementary readings. The first emphasizes the use of welfare to mediate social tensions by incorporating the newly enfranchised working class and legitimizing the existing order (Habermas 1996: 297–299). Otto von Bismarck’s notorious statement that social insurance offered a complementary strategy to his government’s simultaneous “repression of social-democratic excesses” is a classic reference point (Bauriedl 1981: 403). This, though, is to deemphasize the agency of labor itself and perhaps to mistake rhetorical gestures deployed to garner support for evidence of prime motivation, as has been argued in revisionist analyses of Bismarck (Hennock 2007: 94–96, 159). Others are therefore inclined to see social programs as the more direct outcome of labor politics, with the strength of trade unions and the formation of social democratic parties the crucial determinants (Korpi 1983; Elling 1994; Navarro 1989). Britain and the United States apparently conform well to this labor mobilization thesis. The rise of the Labour Party in the Edwardian period can be read as a pressing incentive for British Liberals to adopt policies that countered its appeal. Meanwhile, in the United States, with a labor movement fractured by regionalism and ethnicity and lacking a socialist party to rally “untapped class sentiment,” the Progressives’ NHI proposals lacked political support (Oestreicher 1988: 1278). A frequently cited illustration of labor’s insularity is the rejection of NHI by Samuel Gompers, the leader of the American Federation of Labor (AFL), because it undermined the sectional appeal of the trade union benefits. Perhaps, though, this attributes too much to labor? In Britain, as elsewhere in Europe, socialists did not conceive NHI, and the unions came only later to full support of state health care.

Some therefore find it more compelling to view the state as a site of pluralist negotiation in which political decisions are the outcomes of bargaining between different economic and sectional interest groups, of which labor was only one (Eckstein 1964). Deep social reform was carried only

when solidarities between groups that stood to gain outweighed the influence of those that did not (Baldwin 1990). Key oppositional actors in debates about health care were business, balancing productivist concerns with the cost implications of mandatory financing systems, and the insurance industries, calculating the commercial impact of state incursions into life and sickness coverage. Above all, it was organized medicine that could shape outcomes (Wilsford 1991; Dutton 2007). The obstructive power of the American Medical Association (AMA) has been a recurrent theme in the “why no NHI in the USA?” literature (Starr 1982: 286–289; Quadagno 2005). After initial ambivalence the AMA repeatedly marshaled its political and economic clout to block reform proposals. Meanwhile, in Britain the opposition of the British Medical Association (BMA) to NHI was compromised because some members saw economic advantage in the scheme, as long as generous remuneration was negotiated. Later its hostility to local government irrevocably shaped the NHS as a service based on regionalism and one in which private medicine survived.

However, pluralist negotiation alone does not adequately explain differing outcomes. After all, medical corporations everywhere have sought to defend the clinical and financial freedoms of the doctor-patient relationship and everywhere have exercised peculiar leverage thanks to the “mysteries” of the trade. Even allowing for the dissent of poorer or progressive doctors, it is puzzling that in some places the pressure group veto was exercised more successfully than in others. An alternative explanation may therefore lie with the autonomous nature of national political institutions in facilitating or impeding change.

Historical institutionalism has two key planks. One is to emphasize the agency of the administration itself, with the growth and capacity of the bureaucracy a key determinant of the successful development and enactment of policy (Ashford 1986; Davidson and Lowe 1981; Weir, Orloff, and Skocpol 1988). Thus quite distant phases of state formation could be significant. For example, in Britain the mid-Victorian professionalization of the civil service and the later consensus around a broadly equitable tax system meant that as democracy was extended citizens broadly trusted the agencies of the state (Daunton 1996). In the United States, by contrast, the persistence of patronage and spoils through the early era of mass politics ingrained skepticism toward federal action. This explains, for example, why the Civil War veterans’ pensions scheme proved to be a time-limited program and not the foundation for a more extensive welfare state (Orloff 1988).

The other plank is the polity itself—the structures of the state and

lawmaking processes—and how these shape outcomes (Immergut 1992). From this perspective, the British parliamentary system proved conducive to health care reform because its “first past the post” electoral system typically delivered power to a single party, often with a comfortable majority on which a cabinet government (which initiated almost all legislation) could depend. The traditionally strong party whip, coupled with a fairly streamlined lawmaking process, left opponents with few veto points at which they might intercede. In the United States, however, electoral endorsement and presidential support could be confounded by the lawmaking process: the separation of powers meant legislation could be proposed from different quarters, and even when agreed to, a complex committee process provided multiple stages at which a bill could be blocked (Steinmo and Watts 1995: 343–345). The Democratic Party (the initiator of NHI bills) was a coalition of diverse regional and ethnic interests in which the party whip was weak and congressional members (once Dixiecrats, later Blue Dogs) could bend before pressure politics, perhaps including considerations of local party financing. Thus the AMA wielded more clout than the BMA despite their broadly similar standpoints.

Finally, history matters in historical institutionalism. The sequence in which legislation occurred, or did not occur, determined possibilities for future action—feedback loops—both by reshaping institutions and agents central to the policy process and by recalibrating the costs and benefits attached to subsequent changes (Weir, Orloff, and Skocpol 1988: 16–17; Hacker 1998). Consider the early phase of NHI in Britain: once the BMA had partially surrendered its autonomy in 1911 without catastrophic results, and once NHI had proven itself popular and viable, the scope widened for further reforms (Hacker 1998: 90–92). Meanwhile, early failures in the United States embedded labor’s pessimism about the political route (Stevens 1988: 135). The concept of increasing returns, borrowed from path dependence economics, is also helpful in drawing attention to how early investment in one system drastically limits the possibilities of adopting another. Thus the U.S. rejection of NHI in the 1910s spurred myriad private and voluntary arrangements that both undermined later needs-based arguments for NHI and created new interest groups hostile to further reform (Stevens 1988; Klein 2003). Conversely, Britain’s commitment in 1948 to a single-payer, tax-funded system made prohibitive the costs of later conversion to insurance-based arrangements, despite changing preferences (Lowe 2006).

In sum, then, the tools of political science have furnished an explanation for the development of the British health system that seems cred-

ible in cross-national perspective. Jacob Hacker's (1998) reading, which draws heavily on the work of Rudolf Klein and Harry Eckstein, helpfully illustrates this with its synthesis of relevant cultural and pluralist perspectives within a context of historical institutionalism. For both countries, the 1910s were the critical juncture that determined their future courses. In the United States NHI failed thanks to industry and AMA opposition and labor's divisions, paving the way for private-sector arrangements to emerge. In Britain it succeeded, ultimately not because of prevailing political values or the challenge of Labour, important as these were, but because the polity permitted lawmakers to override interest group positions. Thus while American reformers now confronted the feedback effects of a burgeoning private sector sustaining AMA confidence, and institutional structures riddled with veto points to be exploited by pressure groups, prospects for deeper change in Britain were bright.

Indeed, once established in Britain, NHI developed an "expansionary political dynamic" that reached its "almost inexorable" culmination in a universal tax-funded service (Hacker 1998: 65, 82, 87). Here, with medicine's guild power diminished and oppositional arguments neutralized, a broad consensus in favor of further reform developed, encompassing civil servants, politicians, and doctors. This reflected the strengthening administrative capacity and "policy learning" by health bureaucrats, but it also represented the medical profession's interest. Not only did doctors seek a more secure funding base for the voluntary hospitals, they also wanted a more rational organization of local services that integrated the new expertise grounded in laboratory science with hospital care and the primary interface—in Fox's words, "hierarchical regionalism" (Eckstein 1964; Klein 2006: chap. 1; Fox 1986). Public opinion, already softened toward state health care by NHI, improvements in poor law medicine, and weariness with charitable hospital appeals, also fell into line (Jacobs 1992). Thus further reform premised on extended coverage and hierarchical regionalism was probable thanks to the logic set in motion by NHI, although it took a further critical juncture, Labour's 1945 electoral victory, to carry the NHS package (Hacker 1998: 93–95; Fox 1986: 132–133).

Competing Arguments: Britain

Two trends in the recent history of British health services potentially sit uneasily with this. First, scholars have disputed the degree of interwar consensus, noting instead the highly contested nature of regional planning and the apathy or downright opposition of elements of the medical

profession (Webster 1990). This in turn has reinvigorated the argument about working-class mobilization, with studies of socialist medical activism restoring the place of political ideology (Stewart 1997, 1999). The Labour Party's role in local government has also been explored and connections drawn between commitment to municipal socialism and investment in particular public health services (Powell 1995; Willis 2001). Such work highlights anew the ideas of the organized left and Bevan's socialist values in influencing the civil servants who planned the NHS (Webster 1990, 1998). The emphasis has returned to conflict, not "conflict within consensus," and the final outcome in 1946–1947 now seems more contingent and less assured.

Second, a plethora of studies have been undertaken on the voluntary hospitals, testing, challenging, and developing the claims advanced in earlier texts. A new picture of financing has emerged, problematizing a cornerstone of the consensus argument, which asserts that a crisis of hospital budgets due to philanthropic inadequacy made state funding the only viable option (cf. Klein 2006: 3; Fox 1986: 133). Instead the new hospital history has documented vigorous growth of third-sector hospital contributory schemes, which by the 1930s substantially filled the income gap created when expenditure demands outflanked charitable support (Cherry 1992, 1997; Gorsky, Mohan, and Powell 2002a). Mass scheme membership also facilitated working-class access to hospital governing bodies and a community role in local policy making (Cherry 1996; Thompson 2003). Studies of public opinion have complicated the picture further, showing that although there certainly was strong dissatisfaction with the working of NHI, disapproval of the voluntary hospitals and support for nationalization was less firm than previously thought (Hayes forthcoming; cf. Harris 1983; Jacobs 1992). Labor's position has also become less clear-cut. In some places, depending on industrial structure and local class politics, accommodation with the voluntary sector seemed preferable to public ownership (Doyle 2010). This history also lends weight to Fox's hierarchical regionalism case, because some contributory schemes were integral elements of pan-urban hospital councils, rationalizing funding and provision across a range of public and voluntary institutions (Cherry 1992; Sturdy 1992; Gorsky, Mohan, and Willis 2007). If such planning mechanisms within a mixed economy were indeed emerging at the grass-roots level, it makes the outcome of state hospital provision under the NHS seem rather less inexorable.

It should be stressed that this literature does not speak with a unified voice on the nature of working-class mobilization, the financial health

of the voluntary hospitals, or the viability of regional integration. However, the new hospital history and the recovery of the mass contributory schemes, including the role of labor within them, clearly pose a challenge to the existing historiography. Earlier authors, if they noticed the schemes at all, treated them as bit players—for example, Fox barely referred to them and neglected their role within regional bodies, while Lawrence Jacobs overlooked them in the context of public opinion about voluntary hospital ownership and funding (Fox 1986: 55; Jacobs 1992: 200–203; cf. Hacker 1998: 95). Abel-Smith's classic account dismissed their role in the policy process thus: "The pre-payment agencies . . . were unbusinesslike, ineffectively co-ordinated and run by persons without power or influence. They were swept into the background without antagonizing any important section of opinion" (1964: 499). This judgment now looks too cursory. Here was an organizational form whose membership extended to some 10 million people and that might have become a component of the NHS (Dodd 1957). Indeed, Beveridge had considered a hospital service funded by contributory schemes, and civil servants actively explored the possibility in 1942–1943 (Beveridge 1942: 158–160; Honigsbaum 1989). Thus early plans for the NHS assumed their incorporation, and the retention of an independent hospital sector backed by voluntary prepayment remained a possible outcome. Only when the decision was made in late 1943 (well before the Labour victory) to abandon the contributory schemes in favor of public funding was the way opened for hospital nationalization. Again, this suggests contingency and uncertainty rather than a smooth passage from NHI to NHS.

Competing Arguments: United States

In the United States, revisionism over the last two decades has interrogated dominant assumptions about how the United States' private, employment-based health insurance system came about. One piece of conventional wisdom now under assault is that voluntary sickness insurance in the Progressive era was negligible because industrial plans were financially weak and fraternities primarily interested in conviviality (Murray 2007; Emery 2010; Beito 2000; cf. Schwartz 1965: 452). New work has revealed extensive, attractively priced, and financially robust arrangements for sickness coverage, and this informs the contention that Americans rejected NHI in the 1910s principally because they did not want it. The claim is that because real wages in the United States were substantially higher than in Europe, blue-collar workers were more able to purchase their own medical

care as they saw fit; hence insurance for a cash benefit remained preferable to a Bismarck-style scheme (Costa 1995; Murray 2007; Emery 2010). Institutional structures and pressure politics were therefore less relevant, given labor's satisfaction with the status quo.

This argument does not extend beyond the Progressive period, however, for the rising costs and effectiveness of medicine gradually shifted the imperative from wage replacement to service benefits (Thomasson 2003). Research therefore centers on the timing and causes of the takeoff of employment-based health insurance, a problem also salient to contemporary policy debates about consumer-driven health care. Some commentators trace present inadequacies to government intervention during wartime, which they suggest first oriented coverage toward workplace group health insurance rather than the purportedly more efficient individual coverage (Jost 2007: 54–55; Cannon and Tanner 2005: 67–68; Gabel 1999: 63). It is certainly true that wartime public policies did make group schemes attractive to employers and employees. Wage controls were introduced in 1942, following Roosevelt's desire to stabilize labor relations and curb inflation. Then in 1943 came the exemption from the wage freeze of fringe benefits, including employee insurance plans (Thomasson 2002; Dobbin 1992: 1436–1437). However, these policies came too late to account for the early growth, which dates instead from the Depression (Jost 2007: 53–61). Indeed, analysis of benefits offered by U.S. industries suggests that by 1939 health and accident insurance was already prevalent in 38 percent of large businesses and in 26 percent of smaller firms (Dobbin 1992: 1421–1424). Attention has therefore moved to the 1930s, though opinion is divided on which factors were crucial.

Some analyses point to earlier aspects of public policy. Although Blue Cross hospital prepayment schemes first emerged as civil society organizations, their growth was fostered by state legislatures, which granted them nonprofit status that conferred exemptions from taxation and reserve requirements (Thomasson 2002). The unintended consequence was to create space in the market for private providers. To maintain status as public benefit organizations, Blue Cross schemes were tied to the principle of community rating (a standard premium set regardless of the health status of the insured person on joining). Private insurers could gain a competitive advantage by offering employers a cheaper contract through experience rating (differential pricing that privileged younger, healthier groups). Thus once Blue Cross had demonstrated the viability of hospital prepayment, the legal framework encouraged the insurance industry to

promote competing products to employers (Jost 2007: 57–58; Klein 2003: 208–212).

Researchers have also focused on how the repeated rejections of NHI reshaped the attitudes of labor and capital toward private health insurance. One approach is simply to treat labor unions as vehicles through which rising individual demand was expressed and to see preferences for employment-based coverage as a rational response to price signals: group insurance was comparatively cheap (Thomasson 2003). An alternative earlier reading was that insurance provision was a deliberate industrial strategy adopted by employers to retain employees in a competitive labor market. However, this idea now looks untenable because early take-up was in industries associated less with tight labor markets than with active unionization (Dobbin 1992: 1430). The context was the emergence of new industrial unions and a rapid rise in membership from about 3.6 million in 1930 to 7.28 million in 1940, accompanied by increasingly frequent and effective strikes, particularly to secure union recognition (Gordon, Edwards, and Reich 1982: 177). Insurance benefits could both “appease unions” and “subvert . . . organizing efforts,” albeit with minimal costs to business as they were predominantly employee financed before the 1950s (Dobbin 1992: 1442; Gordon 2003: 56–57). But labor was not entirely reactive, and the progressive politics of the New Deal encouraged unions to support universal health benefits delivered through NHI and public health programs and to initiate novel local services (Derickson 2005: 73–87; Klein 2003: 117–118, 149–160). In this reading it was only with conservative victories in the 1946 congressional elections that labor finally committed to the strategy of achieving health security through negotiations for fringe benefits. Ultimately labor was forced into accommodation with the “resurgent welfare capitalism” imposed by employers (Derickson 2005: 110–111).

Once again this is not a literature that speaks with a single voice. On one side are econometricians who regard the very question “Why is there no NHI in the United States?” as misguided historicism (Murray 2007: 237–247; cf. Fox 1983). On the other are political historians who seek to move beyond the institutional analysis and place at center stage the shifting power relationships between the key economic actors: employers and labor unions (Klein 2003: 9–10; Gordon 2003: 6–9). Their goal is to integrate insights about state agency with pluralist and labor mobilization approaches to derive a multicausal account of how social policy was shaped (Gordon 2003: 9; Dobbin 1992). I argue below that this strategy

of analyzing the “balance of power in the political economy” within an institutionalist framework also provides a helpful way of thinking about the British case (Klein 2003: 9). But first I bring the historical development of the two systems into view.

Hospital Systems and Financing in Britain and the United States, Nineteenth Century to c. 1950

By the start of the twentieth century both countries had developed two-tier hospital systems, reflecting shared assumptions about the proper roles of public and voluntary sectors. The former provided institutions of last resort for the dependent poor, and the latter catered to the self-supporting population (Boychuk 1999: viii, 9–13, 156). Although accessible and affordable, public care was tarnished by the Poor Law stigma attached to the Victorian workhouse (almshouse in the United States). It was also obliged to meet demands of chronic illness and social care and was comparatively poorly resourced (Brundage 2002; Crowther 1981; Katz 1996: 13–15, 30–31). The voluntary hospitals, with their ability to select admissions and their superior levels of funding, led the field of acute care and scientific medicine. In Britain these had proliferated since the eighteenth century, predominantly as middle-class subscriber charities, often oriented to the early industrial workforce and consolidating ties of deference and patronage at a time of rapid urban change (Fissell 1991; Marland 1987: 117–145). Doctors exploited the kudos of unpaid consultant posts to benefit their external private practice; there were few pay beds, and these hospitals essentially remained charities for the working class.

The spread of American voluntary hospitals came slightly later, diffusing inland from the seaboard cities under the impetus of postbellum urbanization and immigration (Boychuk 1999: 53–66; Rosenberg 1987: 18, 100–115; Opdyke 1999: 19–27). In contrast to Britain, patients' payments for board costs were levied from the outset, probably due to philanthropic insufficiency, and this encouraged earlier middle-class utilization. Philanthropic medical service by doctors duly declined more quickly, thanks to the influx of paying patients and the competitive influence of smaller proprietary hospitals reliant on user fees, most numerous in southern and western states. From about 1900, it became the norm for doctors to charge for the treatment of their private patients (Starr 1982: 162–169; Stevens 1999: 20; Rosenberg 1987: 58, 256). Thus by the new century differences in the balance between charitable and private funding had

emerged in the two countries, and each would respond in slightly different ways to new financial challenges.

In the British voluntary hospitals, philanthropic resources came under strain from the late Victorian period due to staffing and infrastructure costs. Demand grew alongside popular faith in the hospital as a temple of medical science, and costs rose with the development of new technologies, whether institutional (electrification, steam heating, laundries, telephone systems) or medical (laboratories, X-rays, aseptic surgical facilities) (Gorsky, Mohan, and Powell 2002a). In response, new modes of collection were directed at lower income groups: the Hospital Sunday funds, which targeted religious congregations, and the Hospital Saturday movement, which amassed small donations made in the workplace. User fees from private patients were also instituted; by 1900 these accounted for some 7 percent of income and the Saturday funds for 6 percent (Cherry 1997; Gorsky and Mohan 2006: 30). Charitable subscriptions changed in character and increasingly became payments from a firm or corporate body rather than the gift of a prosperous individual (Gorsky, Mohan, and Powell 2002b). Middle-class philanthropy was further strained after World War I by rising levels of personal taxation, the influenza pandemic, postwar price inflation, and the cumulative expense of deferred repairs. Government in 1918 examined the possibility of exchequer support, but the voluntary hospital lobby averted this, arguing that an alternative was for Hospital Saturday funds to be formalized into regular monthly collections from employed workers (Prochaska 1992: 92–93; Ministry of Health 1921: 921). The way was now open for an expansion of the contributory scheme as the lynchpin of hospital budgets.

Figure 1 illustrates the changing structure of funding in the British voluntary hospitals, based on statistics reported in hospital yearbooks (for details of methods and underlying data, see Gorsky, Mohan, and Powell 2002a). “Charity,” which includes subscriptions, donations, legacies, church collections, and fund-raising events, was the original mainstay of income and remained dominant in 1900. This underwent a long-term proportionate decline, starting with the 1914–1918 war and broken with only a brief resurgence in the early 1920s when philanthropy rose to meet the postwar funding crisis. The expanding “Fees/Prepayment” category is composed of income from mass contributory schemes and patients’ user fees, including charges for private wards and also typically a means-tested admission fee from which membership of a contributory scheme excused patients; in the larger hospitals the interwar ratio of scheme to fee income was about 75:25 (Gorsky and Mohan 2006). (It should be stressed that

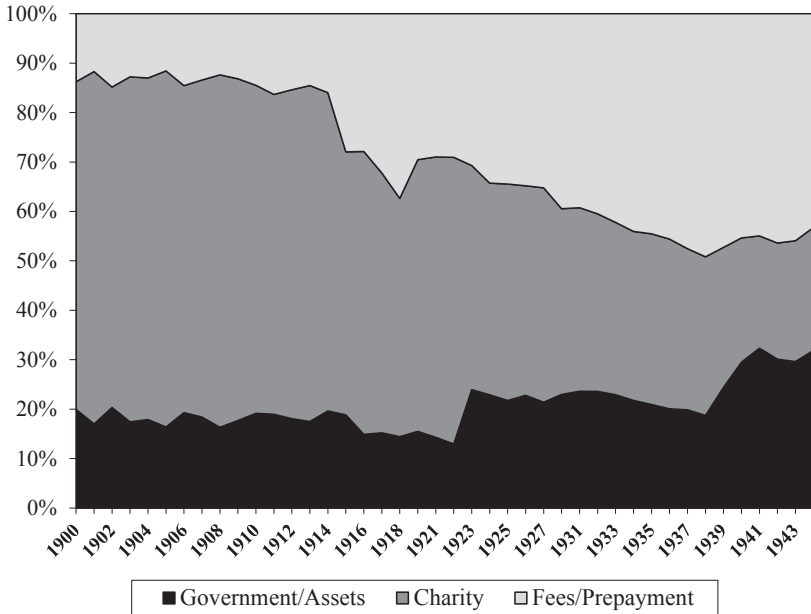


Figure 1 Composition of Income, British Voluntary Hospitals, 1900–1944

Sources: *Burdett's Hospitals and Charities* 1889–1923; Order of St John 1923–1928; Central Bureau of Hospital Information 1930–1944

Note: There are no data for years 1920, 1928, and 1929.

prepayment has a different connotation in the British and U.S. cases; this is explored more fully below.) The “Government/Assets” category encompasses interest on assets — gilts, equities, property — and earnings from contract work, principally for local and national government (the post-1938 hike represents the wartime Emergency Medical Service). The major trend was the growth of fees and prepayment and the relative decline of charity, with the introduction of NHI exerting no influence on developments, because hospital coverage was excluded.

In the United States, similar cost pressures were experienced by voluntary hospitals in the late nineteenth century: rising demand, infrastructural improvement, medical technology, staffing, and current expenditure on provisions and heating (Rosenberg 1987: 238–244). Cyclical economic depression also prompted diversification of funding sources and shunting of costs onto patients (Rosner 1982: 8–9, 45–61). In some places appropriations from taxation played a major role in funding the voluntary

hospitals, and far more so than in Britain. Late nineteenth-century Pennsylvania is the locus classicus; here, in a political system rife with logrolling and interest group lobbying, public funds flowed to private and sectarian hospitals that promised to salve the tensions of rapid industrialization (Stevens 1984a, 1984b). By the early twentieth century, public subsidies covered more than one-fifth of voluntary hospital costs in Pennsylvania, Connecticut, Georgia, North Carolina, and the District of Columbia and also delivered substantial support in New York City and Maryland (Stevens 1984b: 479). After 1910, however, such subventions began changing in character, from general aid to benevolent institutions meeting a public interest to a more specific reimbursement for care of the poor, although support for capital investment continued (Stevens 1982: 569, and 1984b: 487–489). There was no direct parallel in the United States to the Hospital Saturday Funds, although a small number of eastern hospitals benefited from Hospital Saturday and Sunday Association collections (Rosner 1982: 38–41). Only a few isolated prepayment schemes existed, some in employee groups offering cash or service benefits and others contracting directly with doctors. Workers' compensation laws then fueled both employer-driven schemes, notably in the railway, lumber, and mining industries, and also the involvement of commercial insurance companies that administered the program (Vogel 1980; Schwartz 1965). A tiny number of individual hospital schemes similar to the British model flourished, using either the sale of tickets or monthly deductions (Richardson 1945; Williams 1932; Schwartz 1965), but these were marginal. Instead U.S. hospitals addressed charitable insufficiency by extending their user fees, for both board and services such as X-rays (Howell 1995).

Sources for the composition of income in U.S. voluntary hospitals seem more fragmentary than for Britain, but figure 2 presents some illustrative data. The broad categories used in figure 1 are also used here, though underlying these are some important distinctions. Data for 1890 are based solely on Eastern general hospitals, suggesting a similar balance between charity and other income to that in Britain, but presumably understating the importance of patients' payments, which were more prominent in the southern and western United States (Rosner 1982; Stevens 1999). Here "Government/Assets" refers predominantly to interest and dividends, with about 16 percent from a miscellaneous category containing an uncertain portion of municipal government funding. "Charity" is composed of donations and legacies, and "Fees/Prepayment" is predominantly charges but includes 7 percent from Saturday and Sunday funds, which in the U.S. context might arguably be treated as charity (Rosner 1982: 38–41). The

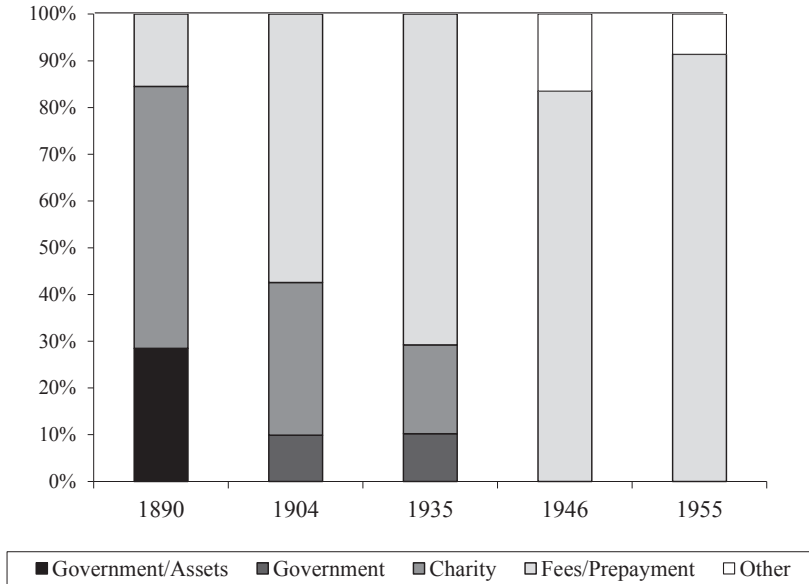


Figure 2 Composition of Income, Selected U.S. Voluntary Hospitals, 1890–1955

Sources: 1890: Rosner 1982: 38–41; 1904, 1935, 1946, 1955: Stevens 1999: 24, 183, 263, 263.

Notes: 1890 $n = 11$; 1904 $n = 1,273$; 1935 $n = 2,857$

latter years are drawn from census and American Hospital Association (AHA) data and are more comprehensive, though again the U.S. terminology and reporting differs somewhat from the British. Data for 1904 refer to records of private nonproprietary and ecclesiastical hospitals and for the remaining years to records of nonprofits. In 1904 and 1935 income from assets is not distinguished, and here “Government” signifies tax funding. Likewise, in 1946 and 1955 income from charity, investments, and tax monies are not differentiated but are subsumed in the “Other” category. Nonetheless, it is clear that the relative demise of charity had occurred earlier in the United States, and by the mid-1930s some 70 percent of income came from patients through either user fees or prepayment. This trend continued after the war (the later sources combine tax and charity income) when income from patients predominated, of which insurance payments accounted for about half of all nongovernmental income by 1955 (Stevens 1999).

Unlike in Britain, then, American hospital prepayment did not have

roots in the Victorian period but was instead a response to the later funding crisis of the Depression. The reasons for this relate to the different traditions of workplace insurance that had developed. In both countries, cultures of working-class association and imperatives of welfare paternalism had embedded habits of collective saving for health benefits. In the British friendly societies, medical assessment and care were part of the benefit package, probably covering some 40 percent of all adult males by 1911, so workplace subscription for hospitalization was a readily acceptable extension (Gorsky 2006: 158). However, for the reasons noted above, industrial sick funds and fraternities in the United States concentrated solely on cash benefits. A preference for a cash benefit with which to purchase medical care on the market was also the norm in trade union funds (Rosner and Markowitz 2003: 53–55). Hence it was not until later than in Britain that hospital coverage was instituted, but by the 1930s it had begun to provide a solution to the funding problems of voluntary hospitals in both countries, and for similar reasons.

The Nature of the Hospital Prepayment Schemes

Precise numbers of British contributory scheme members are uncertain because payments were made by workplace, not by individual enrollment. A widely cited estimate was 10 million by the late 1930s, and because most schemes included dependents' benefits it is reasonable to estimate (using the conventional multiplier for private medical insurance) that about half the population was covered. By 1939 there were 427 schemes, ranging in size from 116 members to over 2 million in London's Hospital Saving Association (HSA). A small number of major urban funds dominated—for example, Liverpool (347,666), Leeds (250,000), and Birmingham (c. 650,000) (Hospitals Yearbook 1941). These were independent bodies staffed by paid organizing secretaries with clerical support that distributed income across several hospitals in proportion to members' utilization (Stone 1927: 220, 225; Voluntary Hospitals Commission 1923). In single-hospital towns the fund might exist independently, relying on voluntary workers and the hospital treasurer, or it might be administered entirely by the hospital.

The schemes collected payments predominantly through the workplace, with volunteers organizing membership within a factory, shop, or office and collecting district subscription levies from the self-employed. Business owners collaborated by arranging payroll deductions, though

efforts to formalize a proportionate employers' contribution on the model of NHI yielded only patchy results (National Archives n.d.; London Metropolitan Archive 1939). Rates were cheap, although they varied widely between prosperous areas of high employment, such as Birmingham, and depressed regions like the northeast coalfields, where no uniform levels were set. Other places linked contributions to earnings on a scale of a "penny in the pound" of wages. Many used an income limit to exclude the middle class, again on the model of NHI, although some simply relied on good faith. Through most of England and Wales the main benefit was exemption from means-tested user fees on admission to a hospital. In the northeast and Scotland, the schemes objected to means testing and fought to sustain an open-door policy by which hospitals were free to all comers. Some larger schemes also offered benefits such as ambulance travel, home nursing, provision of surgical appliances (support and prosthetic items), and convalescence homes (Gorsky and Mohan 2006: chaps. 2–6).

Although the vast majority of schemes had been instigated by hospital managers, control and representation passed quickly to ordinary members (Cherry 1996; Thompson 2003). Grassroots democracy became a key feature, with workplace committees electing delegates to manage the scheme and scheme representatives sitting on hospital governing boards. There were various models. Some major cities established hospital councils on which scheme representatives sat alongside doctors, academics, local politicians, and philanthropic businesspeople (Gorsky, Mohan, and Willis 2007). Elsewhere workers might directly elect representatives to a hospital board. Typically the maximum number was one-third of the seats, even where workers' contributions were the dominant component of hospital income.

In the United States the interwar extension of hospital coverage took more diverse forms. Some commercial insurers writing health plans for employers began incorporating hospital benefits, as did employee schemes organized by trade unions, and a few comprehensive group plans emerged, such as Ross-Loos and Kaiser (Klein 2003: 128–131, 191–192, 208–217; Rosner and Markowitz 2003: 63–64). However, the major development was the growth of the prepayment schemes that became known as Blue Cross and that by 1945 dominated hospital insurance (Klein 2003: 205). Membership took off later than in Britain, in response to the Depression's impact on hospital income. One forerunner was the Baylor Hospital Plan, started in Dallas in 1929, whose success encouraged other group plans covering various hospitals within a given area. Other early examples were in Newark (New Jersey) and Sacramento (1932), St. Paul (Minnesota)

and Durham (North Carolina) (1933), Cleveland (1934), and New York (1935) (Pink 1950). Endorsements from the philanthropic foundations, the Committee on the Costs of Medical Care, and the American Hospital Association then fostered expansion elsewhere (Richardson 1945: chap. 3; Committee on the Costs of Medical Care 1932: 91–92, 132–133).

Payments to Blue Cross plans were made through employee payroll deduction, usually from 50 to 85 cents per month in the 1930s, and membership was initially pitched at both blue- and white-collar workers (the original Baylor plan was aimed at teachers) (Cunningham and Cunningham 1997). The majority of subscribers entered through group funds, with about 5 percent as individuals, and there were some 100,000 volunteer collectors operating in workplaces (Pink 1950: 6–7; Richardson 1945: 17–18). Service benefits were typically twenty-one days of free hospital care per year, with local variations in the provision of dependents' coverage, maternity benefits, co-payments for specialist treatment, and, increasingly, operating rooms, X-rays, laboratory tests, drugs, dressing, and anesthesia (Pink 1950: 26; Richardson 1945: 56–57).

Table 1 shows the growth in numbers of plans and members in mid-century. Following small beginnings attracting largely middle-class members, there was a surge in the late 1930s. This reflected labor's approval of Blue Cross in preference to commercial carriers provided by employers, which it deemed too pro-management. In some places (for instance, New York), the bureaucratic and nonpartisan nature of Blue Cross appealed to labor unions fractured by ideological and ethnic division; here membership growth in the early 1940s was an aspect of the collective bargaining process, with the city government supporting membership of municipal employees (Markowitz and Rosner 1991: 703–707). More broadly, the takeoff in wartime membership reflected the federal government's and employers' interventions described above, which aimed to stabilize labor relations (Cunningham and Cunningham 1997; Klein 2003: 177–190). Against the backdrop of the failure of the Wagner Murray Dingell bills and the entrenchment of health insurance as fringe benefit pursued by labor unions, a substantial postwar expansion occurred. This was carried forward by an economic boom and the political "triumph of accommodation" with the private welfare state, in which health coverage was delivered either by employer-friendly commercial carriers or the union-favored Blue Cross (Starr 1982: 310–334; Klein 2003: chap. 6).

Allowing for the time delay, hospital managers in both countries had devised forms of predominantly workplace-based group prepayment to address their funding needs. Their growth responded to the impact of

Table 1 Numbers and Membership of U.S. Blue Cross Plans, 1933–1951

Year	Plans	Members
1933	6	11,500
1934	10	55,000
1935	17	215,000
1937	26	608,000
1938	38	1.4 million
1939		2.8 million
1940		4.4 million
1945		15.7 million
1947	81	24.2 million
1948		30 million
1951		40.9 million

Source: Compiled from Cunningham and Cunningham 1997: 19, 28, 32, 58, 97

economic depression on hospital income: in Britain the postwar slump and the demise of charity as personal taxation soared; in the United States the Depression, which left beds unoccupied as patients struggled to pay bills. But were the similarities only superficial? Abel-Smith, in an early cross-national survey, argued that the British and U.S. prepayment funds were “completely different,” since Blue Cross was essentially a form of insurance while the schemes were not (Abel-Smith 1972: 230–231). In the United States the basis of membership was a contract among plan, member, and hospitals for limited services at an agreed subscription (Richardson 1945: 51–57). In Britain the service was noncontractual in that hospital care was not guaranteed to members and admission rights remained with doctors, subject to waiting lists.

However, these differences were not as great as Abel-Smith supposed. British members understood that they had an “implied bargain” and that while contributors had no legal right to treatment, they did “possess a strong moral right” (Ministry of Health 1921: 7; *The Hospital* 1931: 211). There were various reasons why a pure insurance model was not adopted in Britain. Depicting subscriptions as voluntary gifts ensured charitable status with ramifications for tax liability; it also reduced the risks of alienating philanthropists or prompting honorary consultants to claim fees. A contractual obligation to provide treatment would also challenge medical authority over admissions and the lay administrators’ control of hospital capacity (Gorsky and Mohan 2006: 108). It is worth noting that early Blue Cross did not aspire to strictly function as insurance but rather to

improve access (Padgug 1991: 798). The Baylor scheme made no actuarial attempt to record costs and length of stay, the hospital's attitude being that "it was more money than they had before, so what the hell" (Cunningham and Cunningham 1997: 11). And in New York there was no explicit linkage between levels of reimbursement and actual costs, because there was no uniform hospital accounting method (Fox 1991: 730). Conversely, although the British schemes did not follow insurance principles, their leaders frequently exhorted members to subscribe at a level that would approximate the actual costs of care (Gorsky and Mohan 2006: 85, 129).

More clear-cut differences related to benefits and social constituency. While British members expected to receive both full maintenance and medical care, Blue Cross benefits specified only accommodation and an agreed range of technical provisions. The prior commercialization of inpatient medical care in the United States had long established the principle of separate charges for doctor's services, which the AMA's fierce opposition to comprehensive group plans with salaried physicians had protected (Klein 2003: 130–131, 155–156, 196). Meanwhile in Britain the swift transition from philanthropic to contributory funding and the relative insignificance of direct fees and charges meant that the long-established culture of free care was not significantly affected. Blue Cross plans also offered differing rates for private or semiprivate rooms and the less desirable general wards, with most members using the former (Pink 1950: 11–12; Richardson 1945: 70). This preference reflects the middle-class character of first-wave Blue Cross subscribers: according to survey data, in 1940 only about 34 percent were blue-collar workers (Richardson 1945: 79). Although promotional material shows that the British schemes had some petit bourgeois appeal, here the changing social gradient of membership ran in a different direction to Blue Cross, with several inaugurating "provident" plans pitched at the middle class (some of which amalgamated after 1948 to develop into the British United Provident Association, one of Britain's leading private medical insurers) (Bryant 1968: 17, 21).

That said, contemporaries saw clear similarities between Blue Cross and the contributory schemes (Dodd 1948: 4). Indeed, British officials claimed that their model had influenced the United States—for example, in the Duke Endowment's studies of the British HSA, which informed the North Carolina plan, and transatlantic visits by Frank van Dyk of New York's Associated Hospital Services (Richardson 1945: 24–25; International Co-operation 1938; Contributory Schemes 1939). At the outset both placed a premium on equity by community rating of premiums, and only later (noticeably by the 1970s) was Blue Cross compelled to

move toward experience rating, following competition from private insurers (Marmor 1991). Both encouraged the integration of services through reciprocal agreements made between funds and groups of hospitals to permit patient choice. In New York, for example, Blue Cross disbursement practices shaped the balance between different types of accommodation and was also involved in planning committees; similarly, British schemes promoted contracting between the municipal and voluntary sectors and had seats on joint hospital councils active in major cities (Fox 1991; Gorsky and Mohan 2006: 80–87, 93–95). Integration was also furthered by national representative bodies, with the Hospital Service Plan Commission of the American Hospital Association encouraging common standards and the British Hospital Contributory Schemes Association (BHCSA) set up in 1930 to deal with issues such as reciprocal benefits between neighboring schemes.

Finally, both were nonprofit organizations that presented themselves as a community-based bridge between citizen and hospital. Organizationally both drew on local and voluntary support: in the United States the church, Boy Scouts, farm bureaus, and chambers of commerce assisted with membership drives, while in Britain thousands of volunteer collectors and hospital fundraisers were used (Cunningham and Cunningham 1997: 15, 69–70; Pink 1950: 8). As noted, this status was recognized in respect of fiscal obligations, with Blue Cross exempt from federal income tax as a social welfare organization (Richardson 1945: 37). Both represented themselves as distinct from commercial insurance: the British deployed the language and imagery of philanthropy and service, and the Americans stressed their role as public-spirited noncommercial bodies, with the Blue Cross symbol, widely adopted in advertising drives from 1934, evoking the charitable Red Cross (Gorsky and Mohan 2006: 106–114; Cunningham and Cunningham 1997: 14; Brown 1991; Rothman 1991). These voluntarist identities meant that despite the organizations' being initiated mainly by hospital managers, participants in both countries laid claim to representation on governing boards (Gorsky and Mohan 2006: 32, 35, 93–99; Cunningham and Cunningham 1997: 28–29; Markowitz and Rosner 1991: 704). The British schemes evolved elaborate electoral procedures connecting workplace contributors to hospital management committees. Minority representation limited real decision-making authority, but sometimes worker influence was genuine—for example, in setting subscription levels and preventing the introduction of local means testing (Gorsky and Mohan 2006: 124–139). In the United States worker repre-

sentation was less extensive, to the chagrin of the unions; despite its community image, Blue Cross remained essentially a provider interest (Starr 1982: 308–309; Markowitz and Rosner 1991: 709–713).

Nonetheless, at the rhetorical level fund leaders in both Britain and the United States appealed to a spirit of self-help and active citizenship. According to its director, the New York plan strengthened “the moral character and the fibre of the community by making people self-sustaining, rather than expecting charitable support or some subsidy” (International Co-operation 1938: 22). The London HSA similarly depicted membership as personal respectability, civic responsibility, and patriarchal duty (Gorsky and Mohan 2006: 109–112). This self-representation shifted during the early 1940s in the face of health reform proposals. In the United States prepayment advocates yoked the benefits of voluntarism to antistatism inflected with patriotism (Brown 1991: 658–659). Now Blue Cross’s leaders claimed that it embodied the “American spirit of neighborliness and self-help”; it was “a distinctively American institution, a unique combination of individual initiative and social responsibility” (Rothman 1991: 681). In C. Rufus Rorem’s words, “Governments tend to emphasize equity not efficiency; certainty not originality . . . experiment or innovation” (Cunningham and Cunningham 1997: 19). Likewise, scheme leaders in Britain evoked “that sturdy spirit of self-help which has had so much to do with the formation of British character,” whereas state welfare would sap “individual enterprise and independence” (Merseyside Hospitals Council 1944: 11, 13). Here too the “initiative and effort” of the voluntary sector was extolled. It could “experiment in ways that statutory authorities can never do. . . . In the ‘totalitarian state’ this might not be so” (Editorial 1936: 3, 2).

Despite their obvious differences, by the 1940s both Blue Cross and the contributory schemes championed nonprofit prepayment within a liberal model of the hospital service. It was a model based on neither state nor market in which ideas about civil society legitimated a strong voluntary sector and in which government’s role was limited to covering the dependent poor. It was premised explicitly on the notion that access to the voluntary hospital was determined by individual effort and self-reliance, albeit expressed through association with group prepayment funds. It was thus clearly distinct from a social democratic model, which treated health care as a right of citizenship and was shortly to be installed in Britain.

The Critical Juncture: Prepayment and Health Care Reform in the 1930s and 1940s

As noted, when policy debate began British civil servants explored the possibility of using the schemes to finance nonmedical hospital costs, with the remainder coming from public funds (Honigsbaum 1989: 157–160). Indeed, Sir John Maude, the permanent secretary at the Ministry of Health until 1945, initially lauded the schemes as the “sheet anchor” of the hospital system, believing they could be retained if only they could achieve regional uniformity so that benefits were standardized across hospitals (National Archives 1942). However, more junior civil servants gradually concluded that diversity and uneven distribution meant the schemes were poorly suited to meet the goals of universal, comprehensive coverage, while the additional transaction costs seemed burdensome (National Archives 1941). There was also a strain of opinion among policy makers holding that widespread participation in prepayment schemes did not necessarily indicate deep-seated attachment to the voluntary system but was simply a pragmatic choice (Beveridge 1942: 160; National Archives 1942). In this view the main achievement of the schemes was to prepare public opinion for further institutionalization of collective hospital payment through tax or NHI. These assumptions underpinned proposals in a 1944 NHS White Paper to substitute voluntary contribution by statutory funding (Honigsbaum 1989: 161–164; Webster 1988: 53–54). This decision would be critical to the shaping of the NHS; once the hospitals were predominantly reliant on public monies, the case for public control became more persuasive. Why, then, did such views prevail?

At this point it is helpful to return to the theoretical perspectives of comparative health systems history. First, what can the institutionalist approach reveal? Given that the crucial decision was taken by the coalition cabinet during 1943–1944, the familiar emphasis on deep change as the outcome of Labour’s 1945 electoral majority cannot apply here, although Bevan would later be unsympathetic to the schemes (House of Commons Debates 1946: col. 47). More telling is historical institutionalism’s interest in the state as principal actor, since it was the bureaucrats of the Ministry of Health who developed the case against the schemes’ place in the planned NHS. Path dependence and the feedback loops of processes set in motion by earlier reforms can illuminate their positions. Once NHI was established in 1911, a parallel unregulated system insuring a different aspect of health care was always bound to attract criticism as less equitable and rational; a view arose of the schemes as a temporary stop-

gap filling a space that government ought ultimately to occupy (Political and Economic Planning 1937: 227, 237, 399, 410–411; Beveridge 1948: 115–116). Arguably the very act of establishing a Ministry of Health in 1918 had created a bureaucratic momentum toward a larger state role, and although interwar resource constraints initially stalled progress the ambition was ingrained in departmental culture, awaiting only the opportunity (Webster 1990: 140–141).

Is this explanation adequate? Returning now to the United States, recall the importance of the institutionalist analysis in explaining Roosevelt's and Truman's inability to establish NHI: the polity tended to impede radical change through the absence of party unity and multiple veto points open to hostile stakeholders. However, pluralist theory also suggests that alongside this must be set the changing positions and relative power of the pressure groups seeking to exercise such vetoes. Blue Cross interests during this period were closely allied to those of the hospital lobby, the AHA, whose Committee on Hospital Service advised the funds and fostered common standards (Stevens 1999: 186–193; Starr 1982: 295–298). The AHA had emerged as a significant pressure group during the New Deal, sustained by a cadre of hospital administrators with a strong professional identity grounded in the private sector. Its lobbying techniques were already well honed in debates over issues such as accessing federal grants and securing exemption from Social Security legislation (Stevens 1999: 156–170). Having initially considered the idea of Blue Cross becoming the mandatory carrier for a statutory health insurance scheme, the AHA became hostile following the 1939 Wagner Bill (Boychuk 1999: 127–130), which proposed publicly administered hospital insurance, raising AHA fears of government intrusion. Subsequent proposals for national hospital insurance in the 1940s were opposed by the voluntary hospitals and Blue Cross, both directly in the policy arena and by molding opinion through publicity that normalized the notion of voluntary insurance as an appropriate model for health security (Rothman 1991: 689–690). Instead the AHA directed its efforts to lobbying for federal support of capital programs, playing a central role in the broad coalition that led to the Hill-Burton Act (Fox 1986: 117–131; Stevens 1999: 212).

Blue Cross was also a beneficiary of the sophisticated and vituperative campaign against national health insurance waged by the AMA, which along with commercial insurers ensured that Republicans and Southern Democrats blocked its passage (Gordon 2003: 220–224; Funigiello 2005: 38–87). Doctors had initially been hostile to prepayment funds, seen as the harbinger of group practice that would reduce the physician to the

status of employee. However, as medical incomes plummeted during the Depression, the AMA gradually acknowledged the virtue of plans that covered hospital costs but not medical fees (Starr 1982: 299–300). Beginning in 1938 state medical societies were signaling approval, and the AMA officially endorsed group hospitalization in 1942 (Richardson 1945: 83–86). Thus doctors came to embrace Blue Cross as a bulwark against something worse: extensive statutory insurance covering medical and hospital services.

The U.S. case therefore directs attention to the interest group arena and to the common cause that voluntary insurance was able to make with the more powerful lobbies of hospital leadership and organized medicine. How do these insights translate to Britain? In fact, the British polity also offered considerable scope for bargaining between interested parties and for the schemes' case to be heard, in both the agenda-setting and policy development phases. Beveridge took detailed evidence before producing his report, civil servants consulted extensively prior to the white paper, and parliamentary debates were held both before and after its appearance. Indeed, the hallmark of policy making before 1945 was the coalition government's desire to construct a service that would satisfy all the interested parties, and it was its inability to find a formula agreeable to the BMA, the voluntary hospital leadership, and local government that stalled legislation (Webster 2002: 10–12). Yet the contributory schemes have barely figured in pressure group readings of the NHS debates (Willcocks 1967; Eckstein 1964). This is puzzling. The schemes' membership was vast and their representative association, the BHCSA, articulated powerful arguments for their survival. These included the claim that the schemes underpinned active citizenship in the welfare state, provided a channel for local participation in health services, and ensured that money would "follow the patient" in an efficient fashion (Gorsky, Mohan, and Willis 2005). However, the record shows that these arguments were sidelined in policy debates, both within the Ministry of Health and in Parliament.

This is because in contrast to Blue Cross, the BHCSA was unable to ally itself with other key actors to defend voluntary financing alongside clinician autonomy and institutional independence. Relations had always been cool with the BMA, which worried that the schemes siphoned away potential paying patients, and no prior agreement had developed. Moreover, the BMA was itself divided, and although its leadership was wary of the NHS proposals, many voluntary hospital doctors were attracted to the promise of more stable funding and reward. To them, finance was less important than administrative structure, particularly the avoidance

of municipal control, which threatened to reduce their status to local government employees. The BMA's negotiating goal with respect to hospitals was therefore to secure the establishment of a new tier of regional management bodies rather than to preserve voluntary modes of finance (Webster 1988: 47–49, 60–61).

The schemes' other potential allies were the hospital leaders, but the British Hospital Association (BHA) was a weak pressure group. Unlike its U.S. counterpart, it was unversed in political maneuvering and failed to articulate forcefully an alternative funding model. Hospital managers had an ambivalent relationship with the scheme leadership. On the one hand they were reliant on their financial support, but on the other they sometimes clashed with worker representatives on hospital governing boards, many of whom were prominent local labor organizers. Nor had the two parties cooperated effectively previously. From the late 1930s the BHA, aligned with the Nuffield Provincial Hospitals Trust (a foundation begun by an automobile magnate), had sought to head off talk of state direction of hospitals by proposing its own model. This was a regionalization scheme focused on the voluntary teaching hospitals and medical schools and incorporating the merger and standardization of all the contributory schemes within each region, to achieve uniform benefits and interhospital reciprocity. However, the schemes' local and parochial sentiments made them unwilling to surrender their sovereignty, and BHA proposals for an NHS led by the third sector foundered. Therefore, once ministry doubts about voluntary financing surfaced in 1943, the BHA quickly abandoned the schemes and, like the BMA, focused on preserving the hospitals' independence from municipal politicians (Gorsky, Mohan, and Willis 2005).

Political pluralism within a historical institutionalist framework thus provides a partial explanation, but it does not resolve the question of why the BHCSA proved so feeble. With its vast membership and close relationship at the local level with organized labor, why could it not exert more influence? In thinking about the relationship between mass participation in voluntary insurance plans and political choices, we now return to the United States. Here the position adopted by labor was significant in the shaping of the health system, though as much for what it could *not* achieve as for what it could.

As noted, labor had not thrown its weight behind Progressive NHI proposals in the 1910s, arguing that they detracted from the greater goal of the living wage and undermined the attraction of union membership (Derickson 2005: 7–8, 12–13). However, by the mid-1930s both the AFL and some unions within the Congress of Industrial Organizations (CIO)

were moving toward support for NHI (Rosner and Markowitz 2003: 62; Gordon 2003: 55). The New Deal era was one of experimentation, when labor-led community health centers as well as publicly funded clinics and Blue Cross seemed to augur alternative models of group practice plans that NHI might ultimately underwrite. Echoing British perceptions, union representatives believed they were “blazing the path” that the state would soon follow (Klein 2003: 131–160, at 153). Crucially, though, the successive defeats of NHI proposals forced a pragmatic reorientation, with both the AFL and the CIO increasingly concentrating on maximizing labor rather than employer control over local arrangements—in some respects a reversion to an earlier struggle to assert workers’ rights against welfare paternalism (Stevens 1988: 135–137).

Then came the wartime surge in voluntary insurance membership. Labor’s gains in this area further directed its health policy away from NHI and public sector provision in favor of security negotiated within the employment contract (Klein 2003: 182). Within this context the long-standing AFL suspicion of statutory health insurance as a threat to organizational strength reemerged; AFL and CIO policy instead emphasized improving representation on Blue Cross boards (Rosner and Markowitz 2003: 62–66; Markowitz and Rosner 1991: 699–701; Gordon 2003: 57–67). The labor unions’ resignation to the futility of pursuing health rights in the political arena also testifies to their notoriously “barren marriage” with the Democratic Party, which vacillated over NHI both during the New Deal and in the 1940s, believing that full employment would solve social welfare questions (Gordon 2003: 276–277). Truman’s support for universal coverage from 1945, even assuming it was not purely for electoral advantage, came when labor was growing ever more committed to employment-based benefits. An alternative social democratic route to hospital insurance was therefore not broadly articulated by the U.S. working class.

In Britain, too, labor’s importance lay in what it did *not* do, though here the outcome was very different than in the United States. The earlier arrival of statutory social insurance had meant there was no analog of the U.S. unions’ struggle for insurance as contractual benefit. Nationally, two broad strategies toward health policy emerged after 1911, with the trade union movement supporting the extension of coverage under NHI and the Labour Party favoring the expansion of a municipal health provision (Earwicker 1982: 11–12, 106–107, 152, 176–183). Locally, however, there were indications that labor could accommodate itself to a system of independent voluntary hospitals sustained by contributory schemes (Doyle

2007, 2010). These were replete with dignitaries from trade unions, trade councils, cooperatives, and friendly societies whose involvement signified both a commitment to civic action and more practical concerns with the level of payroll deductions and the employment rights of hospital workers (Gorsky and Mohan 2006: 101–105, 114–116). Governing rights on hospital management boards were also highly valued, such that their later removal under the NHS was to be a great source of rancor (Webster 1988: 277–279). Why then could the BHCSA not muster sufficient support from its constituents in the labor movement to strengthen its hand as a pressure group?

The answer is that despite their apparent accommodation with the voluntary hospitals, many working-class contributors looked forward to “state organised and subsidised hospital services” (League of Subscribers 1947). This aspect of labor’s role has gone unnoticed, both because it expressed itself as diffidence—what was not done—and because evidence lies buried in contributory scheme records. Active support for a public hospital system was particularly prominent in cities where socialist ideology was more intense, such as Leeds and Liverpool (Doyle 2010; Gorsky and Mohan 2006: 115). Thus the BHCSA’s efforts to mount a defense of the movement following the white paper were compromised from within as “Labour men” refused to lend support (Gorsky, Mohan, and Willis 2005: 186). In contrast to the U.S. situation, the unions had no investment in the schemes as a source of organizational strength, and there were good reasons why the new proposals looked more attractive. Financing hospital care through local or national taxation or NHI was more progressive in that it redistributed costs equitably and systematized employer contributions.

As a pressure group, the BHCSA was not only disadvantaged by its lack of external allies. It was also internally disabled by bands of its own membership who were either apathetic or hostile to its survival. Indeed, BHCSA pessimism was expressed as early as 1935: “The main supporters of the Contributory system . . . are wage-earners and . . . Trade Unionists . . . identified with the Labour Party. The Socialist party was bound to support . . . a State Service, and sooner or later, the voluntary hospitals would come under State control” (BHCSA Conference Report 1935).

Conclusions

In concluding his study of the origins of private social insurance in the United States, Frank Dobbin (1992: 1419) made a plea for the synthesis

of institutionalist and pluralist approaches to welfare state history. His argument was that processes of state formation were of obvious importance to the United States' distinctive trajectory, in that the lack of federal bureaucratic capacity made an early move to NHI unlikely. However, the feedback loops established by early policy choices also mattered because they refashioned the positions adopted by the different interest groups, notably employers and labor unions. Thus "group behavior" becomes "an intermediate variable between institutional context and organizational and political choices" (Dobbin 1992: 1420). The present discussion echoes this call for synthesis from the perspective of the British case.

I began by setting out the problem of reconciling new British findings about the pre-NHS hospital with existing accounts of health system change. The argument was that mass contributory schemes in the interwar period both consolidated the hospitals' funding base and opened up new possibilities for system integration and community control, while apparently sustaining a voluntary ethic of responsible citizenship. This history weakens the claim that a dominant technocratic consensus in favor of reform emerged during the 1930s, with only the fine detail to be determined. Instead a mixed economy of funding and provision might have been secured, which suited key interests: the doctors, with their aversion to becoming public employees, and the voluntary hospital leaders seeking to preserve independence. Our understanding of the coming of the NHS is therefore incomplete without examination of why this model was rejected. I further argued that this history bore various similarities to developments in the United States. Both countries maintained two-tier hospital systems through the interwar period in which the public sector was associated with dependence and stigma and the voluntary sector with self-reliance and local autonomy. Both transformed their funding structures as charity became inadequate in favor of user fees and prepayment schemes; like the schemes, Blue Cross furthered regional integration and promoted voluntary effort. It therefore seems appropriate to apply to Britain the analytical approach developed in the United States by scholars such as Dobbin, Jennifer Klein, and Colin Gordon.

The resulting discussion endorsed elements of the historical institutionalist position, though in a nuanced way. Just as Hacker argued, the earlier adoption of NHI, with the limited 1911 benefit package, was critical in establishing a path-dependent process. The supplementary form of hospital cover that rose to fill the gap suffered from an unfavorable policy feedback, in that voluntary contribution was always likely to appear inconvenient and inequitable by comparison with statutory insurance. Pol-

icy makers with an open mind toward a larger state role were therefore inclined to interpret the schemes not as a viable alternative but simply as evidence for mass acquiescence toward formalized hospital funding.

However, this in itself did not make the transition from NHI to NHS inevitable. The demise of the contributory schemes was sealed well before the Labour Party's electoral majority brought the full weight of centralized political power to bear on health system reform. Instead their rejection occurred in late 1943, in the midst of a period of negotiation among stakeholders during an unusual interlude of coalition politics in Britain. Furthermore, the contributory schemes initially had some sympathizers within the bureaucracy and had several opportunities to make their case in the political arena. The analysis therefore turned to the role of pressure group politics, which has been so prominent in the U.S. historiography. In contrast to Blue Cross, which aligned with the hospital and medical leadership in opposition to NHI, the British schemes remained tactically and temperamentally distant from these lobbies. Their representatives were therefore isolated and weak during the open, consensus-seeking phase of policy making between 1941 and 1945.

The U.S. literature also emphasizes the changing relationship between labor and business in shaping the United States' public-private welfare state. The absence of a social democratic party advancing a health platform, and the inability of reformers to carry NHI in the 1910s and 1930s, drove U.S. workers to seek health security as a right of employment, not of citizenship. This too can inform the British case. Although recent work cautions against assuming a homogenous labor position, here the political circumstances allowed labor to influence outcomes very differently. For many leftists within the contributory scheme movement, participation was a temporary phase in the march toward the collectivized services envisaged by the Labour Party. Thus the rhetoric of the voluntary ideal propagated by scheme and hospital leaders was not uniformly supported by a mass membership, whose diffidence or opposition fatally inhibited the ability to mobilize as a pressure group. Here was a reason for the "public preferences and socially shared understandings" in favor of open access and public ownership of hospitals that pollsters picked up in 1943–1944, at least from some sections of the population (Jacobs 1992: 207). This hardly amounts to a positive restatement of the labor mobilization thesis as the principal determinant of health system change. But it does reaffirm the importance of labor's position in the balance of forces that brought about the British NHS in 1948.

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