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The evolution of health care in Britain

During the 18th and 19th centuries there was continuous debate about poverty, its importance for the nation, and how the wealthy should respond to the indigent. From those times right up to the earlier years of this century, Britain has oscillated between fears of over-population and a dread that, with declining birth rates or high mortality rates, the population may be declining. Too much population growth might jeopardise the nation's self-sufficiency in food. A sick or declining population may jeopardise the nation's security by weakening its ability to defend itself. Poverty was obviously associated with disease of all kinds, and too much poverty was therefore a threat to peace and security. The poor died in large numbers whenever their malnourishment was exacerbated by poor harvests. Typhus regularly followed in the wake of bad harvests, as in 1718, 1728 and 1741.

The answer to this uncertainty seemed to be a census, as had been undertaken already by that time in Sweden and other European states, However, when Mr Thomas Potter introduced his Census Bill to parliament in 1753 it caused great consternation.[25] If the country was really weak, disclosing the numbers would encourage its enemies. Census-taking was also thought likely to incur the wrath of God, for the bible tells how King David's Census of the Hebrews was never completed because of a plague. The Rev. Richard Price's *Observations on Reversionary Accounts* set off another bout of fear when published in 1780. He claimed that through debt, disease and poverty, 'amidst all our splendours we are decreasing so fast, as to have lost, in about 70 years, near a quarter of our population'. Price saw the growing towns as the source of conditions giving rise to poverty,

disease and death.[26] The comfortably situated felt a strong need to act for the security of the nation, but all of that was changed by Thomas Robert Malthus, clergyman and economist of sorts, with publication of his *Essay on the Principles of Population* in 1798.[27]

Malthus' ideas, or rather their too-ready acceptance, set back by 100 years the cause of poverty, and poverty of health. Malthus taught that populations expanded in geometric progression, doubling in size about every 25 years, whereas their subsistence could not possibly grow faster than in arithmetic progression, an increase by a constant quantity every 25 years. Since no people can exist without subsistence, nature must either cull by an increased mortality among the weak, or the people themselves must postpone reproduction. Malthus taught that famine, disease, vice and misery (the positive check) were nature's way of culling those sectors of society that bred beyond the limits of their subsistence. These ideas were fought bitterly by many, William Godwin and William Cobbett for example, but for all-too-obvious reasons the Malthusian doctrine was the preferred explanation for the existence of poverty by the affluent. It also harmonized with the theory of wages at that time, which was that they were paid from a finite amount of capital. Increasing numbers of labourers could only mean a reduction in wages. But the reasoning led to even worse conclusions. If the wealthy were to spread their wealth among the poor, nature's 'positive check' would be thwarted. The poor would reproduce even more, wages and subsistence must fall, and the outcome would be common misery and the decline of civilisation. Malthus campaigned against the Poor Law, believing that relief would encourage births among the destitute. The first edition of Malthus' book ran to 50,000 words, but so popular did it become that he was emboldened to enlarge on his doctrine. The sixth edition of 1826 ran to 225,000 words and translations appeared in several languages. Engels, describing English attitudes in the early 1840's, found the Malthusian doctrine 'the pet theory of all genuine English bourgois'.[28]

A commission appointed in 1833 to examine the administration of the Poor Law was inspired by Malthusian doctrine. Its conclusion - the system was ruining the nation. The New Poor Law, passed in 1834, was barbaric in nature. Relief in the form of money and provisions was abolished. The destitute were henceforth to be admitted to workhouses (known popularly

as Poor Law Bastilles), in which conditions were made deliberately severe and repressive. Families were split up to prevent breeding. The work undertaken by the inmates was chosen so as not to compete with private enterprise; stonebreaking for men and the picking apart of old rope for oakum by the women and children.

Several philosophers and economists took up the cause of Malthus, among them Herbert Spencer (1820-1903). Spencer believed the poor to be of defective moral character. If the poor were given more than the absolute minimum, moral decline would permeate good society. Poverty was the necessary reminder to society of the consequences of laziness and lack of moral fibre.[29] When Darwin published his *Origin of Species* in 1859, his ideas about evolution in biology were immediately manipulated by Spencer to give scientific credence to his beliefs. It was Spencer who created the ideas behind 'social Darwinism'; and it was Spencer, not Darwin, who introduced the phrase 'survival of the fittest'! Victorian intelligentsia saw mankind stratified in evolutionary terms, with the aboriginal peoples at the bottom, the British upper classes at the top, and the British poor somewhere in-between. The society of William IV and Victoria promoted theories which appeared to justify the status quo with its rigid hierarchy. To show concern for the needs of the poor, even their health and high risk of premature death, was to flout the laws of God and nature, as supported by the latest of scientific ideas.

The dawn of enlightenment

There were, however, practical problems to arise from the doctrines of Malthus and Spencer. Firstly, the poor themselves and the more philanthropic among society did not see things eye-to-eye with these gentlemen. Secondly, the infectious and contagious nature of many diseases, and their links with squalor were recognised many decades before the theory of germs was promulgated. The middle and upper classes were by no means immune to the ravages of tuberculosis, typhus and smallpox. But it was the arrival of cholera in Britain that spread fear and panic across the nation. On 4 November 1831, the first case was diagnosed in Sunderland. A massive epidemic of cholera swept the country in 1832, and another in 1848-9. The population had not experienced this disease before, and its arrival brought

terror and rioting. The popular belief that it was spread by a miasma of foul air led to increasing demands for sanitary controls, water management and waste disposal. Edwin Chadwick was Secretary of the Poor Law Commission when he acted as main author of the *Report on the Sanitary Conditions of the Labouring Population of Great Britain*, published in 1842. This document, presenting the results of a study of the relations between ill-health and environmental conditions, concluded that the most important measures to be undertaken by local authorities were drainage, removal of refuse, and improvements in water supply. Parliament responded by passing the Nuisance Removal and Disease Prevention Act of 1848 to deal with the second cholera outbreak. In the same year the Public Health Act established the first General Board of Health, together with District Boards of Health wherever the Registrar General found the death rate to be above 23 per 1000.[30,31]

Pressure from public figures such as Charles Kingsley and Michael Farriday, and a better understanding of communicable diseases, led to a succession of legislative reforms concerned with slum clearance, the isolation of patients with infectious disease, and environmental sanitation. The Public Health Acts of 1872 and 1875 defined local authority responsibility for sanitary measures and established effective measures which saw mortality rates fall from 22 per 1000 in 1871-1875 to 17.7 per 1000 in 1896-1900.[6]

These actions were all put on a more scientific footing with the growth of the science of bacteriology following the identification of the organism responsible for anthrax by Koch in 1876. Of every 1000 deaths in males between 1848 and 1872, 146 had been caused by tuberculosis and 13 were from smallpox. By 1900, the respective numbers were 84 for tuberculosis and 1 for smallpox.[32] Around 1870, children aged 5 to 9 years were dying annually at a rate of 7/1000, but by 1900 this had fallen to 4/1000.[6] In 1880, however, the Malthusian doctrine was still so strongly held by many of the intelligentsia that Henry George felt compelled to devote no fewer than 4 chapters of his best seller, *Progress and Poverty* (1879), in refutation.[33]

The health of the poor

The poor had traditionally sought care for sickness in the voluntary hospitals maintained by the monastic institutions and other charities. By the

middle 1800's they could handle only a minority of cases. For example in 1861, there were 50,000 sick paupers in the wards of the workhouses, and 11,000 patients in the voluntary hospitals. It was partly to deal with the sheer numbers of the sick that two Acts of the 1860's required local authorities to establish isolation hospitals, fever hospitals and mental asylums. But the New Poor Law held its grip, and there was to be no relief for the underlying poverty. Even in 1900 the elderly poor were still carried to the workhouse by their sons and daughters.

In the 1870's the data in the General Register Office were first put to an examination of death rates within the strata of British Society. In 1874, Charles Ansell tabulated the mortality experience of the upper and professional classes. Of every 100 children born to peerage families, about 12 would not survive to 10 years of age. For the upper classes the respective number was 15, and for the general population, about 30. In 1887, Noel Humphrey, Assistant Registrar General, stated that it was 'urgently desirable that we should know more about the rates of mortality prevailing in the different strata of society'. Essentially nothing more was done in this regard, however, until Dr Stevenson's tabulations of 1911, as noted earlier.[4]

British Society at the turn of the century

The industrial revolution and the Victorian expansion of Empire made London the financial centre of world trade. The huge increase in wealth and opportunity were most unequally shared between the classes, the regions and the sexes. The newly rich through trade and industry aspired to and were drawn into the ranks of the older landed aristocracy, acquiring land themselves. By 1900 the new upper class was an amalgam served in the House of Commons by 250 bankers, merchants, company directors and other leaders of trade, together with 70 Lords, Baronets and other titled personages. The limitation of franchise meant that political divides were more on religious lines than class lines at this time, in the shape of the Conservative and Liberal wings of the middle and upper classes. The Independent Labour Party did not exist until 1893. Full manhood suffrage had to wait until 1918; at the turn of the century only about 60% of British men had the vote, and the 40% without were mostly working class. Enfranchisement for women was not completed until 1928, and even up to

the launching of the National Health Service in 1948, businessmen and university graduates had two votes to everyone-else's one. The lower socio-economic classes had little or no political influence over their own status or health until after 1918; they took what they were given. England was in those days a very good place for gentlemen, whose comfort rested on an unlimited and cheap supply of labour, especially in domestic service, and an income tax so moderate as to be almost negligible.

Two themes came to dominate politics in Britain over the period 1890-1910 (along with other issues such as Free Trade), both of fundamental importance for this analysis. One was a developing programme of personal social services for the alleviation of the worst effects of poverty and the control of disease; the other was the means for financing this programme.

Development of Personal Social Services

Public opinion came more and more to believe that high death rates in infancy and childhood were not inevitable dictates of nature, and that poverty and squalor were at the root of much of it. By the end of the nineteenth century, Sir John Simon, Medical Officer to the Privy Council, was able to refer to poverty as 'among the worst of sanitary evils.'[34] From 1890 onwards pressure began to grow for measures to intervene against poverty and ill-health at a personal level as well as at the level of public health. The first sign of movement in this direction came with the Workmen's Compensation Act of 1897, under which the employer was considered to be liable for the results of industrial injury.

The South African war of 1899-1902 provided a further jolt to the public consciousness when about half the working men who volunteered for active service had to be rejected because of ill health, mainly poor physical development, heart disease and poor eyesight. There were also reports detailing the poor physical health of adolescents seeking work in factories. A subsequent Inter-Departmental Committee on Physical Deterioration recommended that schoolchildren should be inspected medically at frequent intervals; and that school meals should be organised by local authorities. Here then was the cradle of the 'reactive' approach to the ill-health among the materially deprived, legislation directing local authority services to alleviate suffering from which the poor were unable to relieve themselves.

At this time the only public medical service outside the voluntary

hospitals was that under the Poor Law. The working population was slowly increasing and life expectancy was growing, and the infirmary wings of the workhouses could not cope with demand. Two thirds of the sick were in these institutions; understaffed, unspecialised, and with no visiting physicians or surgeons. Poor Law district medical officers offered a rudimentary domiciliary service, but they were underpaid, disliked by private physicians, and were not expected to advise on disease prevention. The Poor Law system came to be regarded as quite inadequate, and so a Royal Commission was set up between 1905 and 1909 to examine its operation. The majority of the Commissioners were concerned to find ways to improve its operation. Among measures proposed were the transfer of responsibility from the Poor Law Guardians to county and county borough councils, the replacement of the workhouse infirmary by specialised institutions, and the creation of dispensaries with attendant doctors for the low-paid, on payment of a subscription.[35] A minority report, whose best known authors were Beatrice Webb and George Lansbury, wanted abolition of the Poor Law and attention to the causes of poverty.[36]

The Liberals were swept to power in a landslide victory of 1906, with Campbell-Bannerman as Prime Minister. He made clear the Party's intentions for social and financial reforms. The social programme was to be funded in large measure from site-value taxation, or as he put it, by making the land 'more of a treasure house for the nation'.[37] Asquith replaced the ailing Prime Minister in 1908, and chose Lloyd-George for his Chancellor of the Exchequer. Lloyd-George was an ardent land reformer, and a man who believed that poverty was caused by a lack of opportunity for work, sickness and old age. In 1908 the Government introduced the Old Age Pensions Act which provided for a fixed weekly sum out of central taxation for all persons aged 70 years or more who satisfied certain requirements (7s 6d for a married couple). Then in 1911 came the National Health Insurance Bill, introducing a public scheme paid for in part by insurance contributions. The aim was to relieve poverty among workers with incomes of less than £160/year (gradually raised to £420/year by 1942) by providing a sickness allowance and a minimum medical care service (not covering dependents).

This approach to poverty through relief had a long and very understandable precedent. During the 17th century, at a time when people were rendered

destitute mostly by natural disaster or personal misfortune (famine, flood, disease, accident), the reactive response was logical even if very inadequate. The voluntary hospitals and the charitable actions of medical men likewise were humane and indispensable responses to the suffering of the poor. There were those in the late nineteenth century, however, who had come to recognise that by that time by no means all poverty and disease was the result of natural disaster or personal misfortune. They saw that much of the social ills around them were now man-made, a consequence of the political economy, and they doubted whether in these circumstances the "reactive" approach to poverty and its consequences amounted to an effective response.

These reactive responses to society's ills needed finance, and here also the precedents had been set long previously. The Poor Law was financed through parish relief, and then eventually through larger local authorities. Income tax was introduced as a temporary measure during the Napoleonic Wars at the beginning of the nineteenth century, and became a permanent and growing feature of the tax system in 1842.[38] The initial imposition of 7d in the pound (3%) was varied subsequently to reach a peak of 7% on annual incomes of £100 or more during the Crimean War of 1854-1856. At this time, however, there were less than 500,000 taxpayers in a population of 12 million persons aged over 15 years. In his budget of 1909, Lloyd-George relied mainly on the standard forms of taxation to finance his social programme (though he would have preferred otherwise). He introduced 'progressivity' into income taxation, with a 'supertax' of 1s 8d (8%) in the pound on incomes of over £5000 per year (more than £100,000/year at current values). The increases in income tax were expected to raise an extra £3.5 million, those on estate duties a further £2.85 million, and licences and taxes on tobacco and liquor an additional £6 million. At this time there were fewer than 1.5 million taxpayers in a total population of just over 40 million, and since the large majority of the working population was not contributing, income tax could be regarded as genuinely redistributive.

The Alternative Solution

Not everybody, even in the late 19th century, accepted the principles that had led to relief of poverty in the ways employed at that time. An emerging body of opinion, largely in and around the Liberal Party, was promoting the

idea of some form of land tax for central revenue after 1880. State expenditure was less than £100 millions at that time, and some, particularly the advocates of the philosophy of Henry George, realised that a 100% 'tax' on the annual site value of land would cover this amount and leave a respectable surplus as a fund for social improvements. All taxes could therefore be replaced by a 'single tax', a phrase that gained rapidly in popularity not only among the Liberals after 1888, but also among the labouring classes and their organisations. Sidney and Beatrice Webb recorded how the philosophy of Henry George had completely changed the attitudes of urban workers by the 1890's. The old Chartist cry of 'Back to the Land' was replaced by a call for 'the unearned income of land - site value rating'.[39] Gladstone's Liberal government of 1892 championed land reform, but lacking an overall majority and faced with enormous opposition from the Conservatives in the Commons and the Lords, could achieve very little. Sir William Harcourt was, however, able to introduce a death duty on landed property at a rate of 8% in 1894.

The liberals wanted to shift the tax-base onto rent, but this required a preliminary valuation of the nation's land, and here was the stumbling block. Two Bills introduced for this purpose in 1907 and 1908 were wrecked by the Lords. To circumvent this difficulty, Lloyd-George determined to incorporate proposals for land valuation in his budget of 1909. He proposed 1d in the pound (later dropped to °d or 0.2%) on the capital value of undeveloped land and a 20% duty on the incremental value of land when sold or inherited. These new land measures, though sufficient only to raise £500,000 and hardly amounting to any meaningful tax on land values, were nevertheless the thin end of the wedge for the Conservative opposition and provoked a famous constitutional crisis. The Finance Bill did not reach its third reading until November of 1909, only to be wrecked by the Lords, so precipitating the general election of January 1910. This time the budget, with its land-valuation provisions, passed the Lords, after which the Government introduced its Parliament Bill to curb the powers of the Upper House, especially those over Finance Bills. Another rejection by the Lords led to another election at the end of 1910. Finally the Conservative's majority in the Lords decided upon abstention, and the Parliament Bill was passed.

Nearly 5000 land valuers were set to work, but Lloyd-George did not see

completion of their task before 1915. His 1914 Budget statement prepared the way for a Bill to value land and improvements separately for local (but not national) purposes. A Ministry of Lands was under consideration when all was disrupted by the outbreak of war. During 1914-1918 the Government was forced once again to rely on enormous increases in income tax, with top rates in excess of 50%. After the war these rates fell back, but never again to pre-war levels. By the Finance Act of 1920 the obligation to complete the valuation of all land in the United Kingdom ceased.[40] Thus a concerted attempt to remove poverty by collecting revenue for central purposes from site-values failed. Instead, the events of 1909 to 1911 set the stage for the evolution of welfare capitalism as we know it today.

The National Health Service

In many ways, the outline of the National Health Service of 1948 onwards was laid down by the Consultative Council on Medical and Allied Services appointed by the first Minister of Health, then Dr Christopher Addison, under the chairmanship of the future Lord Dawson, as part of national reconstruction after 1918.[41] Medical knowledge was expanding and treatment becoming more specialised, making extended organisation essential. The system proposed had five forms of service, namely domiciliary, primary health centres (the forerunner of the group general practice plus cottage hospital), secondary health centres (district general hospitals), supplementary services (special institutions for fevers etc), and teaching hospitals. The service would be administered at local authority level, co-ordinated by the Ministry of Health. Owing to the state of the economy in the early 1920's, however, nothing was done to implement these suggestions. Voluntary hospitals were to continue, with central grants at times of financial crisis.

Over the following 20 years there was some growth and development, but the pattern of services changed little and co-ordination and co-operation was patchy. A report from the Hospital Almoners Association disclosed that in 1939 conditions were almost everywhere poor, but more so in the North than in the South. Shortages of specialist services were very evident, and costs for the non-insured delayed diagnosis and treatment.[42] An editorial in *The Lancet* summarised the position in the following way:

> Even before the war, there were voices crying in the wilderness that all was not well with the medical services. The burden of their cries was that

> preventable diseases are not being prevented; that the chances of avoiding death in infancy, in childbirth, from tuberculosis, and from rheumatic carditis were much greater among the rich than the poor; that for most of the population such financial burdens were added to the burdens of ill health as to discourage early treatment; that the standards of treatment available in different places and institutions, and among different social classes, varied enormously; and that the annual income of those who cared for the sick ranged from £40 plus keep and laundry paid to the probationer nurse to the £40,000 earned by the successful surgeon.[43]

In 1939, a married woman had no access to free medical attention unless she was pregnant or had recently given birth. Her children of school age came under the care of the school medical inspector. Many women would not 'start a doctor's bill' if they could possibly remain on their feet. Health standards in many families were very low, and the plight of the elderly infirm was pitiable. The intention was for the National Health System to correct this situation.

Plans for a comprehensive health service evolved over the years 1939 to 1948. Discussions involved the Ministry of Health (which was hoping to move towards a comprehensive medical service), the general practitioners through the British Medical Association (which was concerned to retain payment of doctors by a capitation fee through the National Insurance System rather than by a salaried service), representatives of the Local Authorities, and the voluntary hospitals. Much time was spent by the Minister of Health trying to reconcile the differences between the various parties. In December 1942, however, the Beveridge report was published.[44] The Beveridge committee, with Beveridge as chairman and senior civil servants from government departments that administered the various forms of social security at that time, had been asked for recommendations on their integration and possible extension. They proposed a single universal social security scheme covering loss of earnings through sickness and disability, unemployment or old age, with flat rate contributions and benefits and additional assistance based on a means test, all administered by a Ministry of Social Security. The report also included the famous 'Assumption B', that there would be a comprehensive health service available to all and divorced of any conditions of insurance contributions. Without such a service, the social security system would flounder. Doctors, however,

wanted an income limit for eligibility to protect private practice, voluntary hospitals were concerned to maintain their status, and the medical profession in general did not want local authority control. The matter eventually reached Cabinet and a White Paper on a National Health Service appeared in 1944, as a consultative document. The objective was stated quite clearly. 'The Government want to ensure that in future every man and woman and child can rely on getting all the advice and treatment and care which they may need in matters of health; that what they get shall be the best medical and other facilities available; that their getting them shall not depend on whether they can pay for them, or any other factor irrelevant to the real need - the real need being to bring the country's full resources to bear upon reducing ill-health and promoting good health in all its citizens.'[45]

The costs of this service were to be borne very largely through central and local taxation. These were estimated at £132 millions compared with £54.5 millions in 1938-1939 for an incomplete service. Average wages in 1939 were £180 per year, and there were fewer than four million taxpayers at that time in a working population of more than 20 million. Clearly therefore, the Government saw the health service as a means of redistribution of wealth in kind to benefit the health of the lower social classes. The service was envisaged to pay for itself by reducing sickness rates and thereby the need for social security, and by lowering the economic waste of premature disability and death.

The Labour government was swept to power in July 1945, with Aneurin Bevan as Minister of Health. The first task was to decide on the organisation and administration of hospitals, which the wartime caretaker government had struggled with for some time. Bevan's answer was straightforward; all hospitals should be taken into national ownership and administered by local bodies with delegated powers. Financing of the scheme was planned only partly through National Health Insurance (to become simply National Insurance), amounting to £35.7 millions, the Exchequer contributing £103.3 millions and the local rates £6.0 millions.[46] Bevan's National Health Service Bill of March 1946 revealed a tripartite structure. The Minister would be directly responsible for hospitals and specialist services, but would act through new regional and local bodies. County and County Borough authorities would be responsible for health centres, clinics and domiciliary services. Executive Councils, half professional and half lay,

would administer general practitioner services of doctor, dentist and pharmacist.

Between 1946 and 5 July 1948 when, with the National Insurance Scheme, the National Health Service became a reality, an immense amount of administrative re-organisation was undertaken against bitter opposition from the British Medical Association. Bevan steered a course through this resistance and doubts among the Cabinet, with the support of the Royal College of Physicians.

The National Health Service has been in many ways an undoubted success compared with the pre-war situation. It took the commercial element out of medicine. Doctors could practice without considerations of profit or the patient's financial losses. The hospital system was improved immensely. It operated in tandem with national insurance to offer security against the immediate distress of unemployment and illness. However, the principle that the health service should be provided free at the time of need was soon breached in minor ways and has repeatedly been under threat over the past 35 years. Prescription charges, dental charges and opticians' charges have all come about partly to raise revenue and partly to deter abuse. In reality of course, the service was never 'free' but paid for by taxation of wages and interest. Since 1960, essentially the whole working population of Britain has been eligible for taxation and, through various adjustments to income tax rates, progressivity has been diminished. Furthermore, the introduction of value-added tax firstly at rates of 8% and 12.5%, later at a single higher rate of 15%, has made the tax system even less progressive. The 1979 Report of the Royal Commission on Income and Wealth disclosed that between 1949 and 1979, the share of total 'after tax' income taken by the top 10% of income earners fell only from 27.1% to 23.4%, and over the same period the share taken by the bottom 30% also fell from 14.6% to 12.1%.[47]

The Family Expenditure Survey has shown that in 1986, income-in-kind from use of the National Health Service amounted on average to £910 for families in the bottom 20% in terms of original income (ie, income from employment, occupational pensions, gifts and investments). For the top 20%, the average was £710. For housing subsidies, the respective incomes-in-kind averaged £130 and £20. For educational services the gradient was reversed; £270 for the bottom fifth and £850 for the top fifth.[48]

The Black Report

In March 1977, David Ennals, Secretary of State for Social Services, drew attention to what he called the 'worrying' differences in mortality rates between the social classes. He considered attempts to narrow this gap in health standards a major challenge for the next decade. Accordingly, he appointed a Research Working Group, chaired by the President of the Royal College of Physicians (Sir Douglas Black), to examine the evidence and draw implications for policy. Its work was completed in 1980, by which time there had been a change of Government. It concluded that the social class differences were not only real but sharpening, that they accounted for the loss of tens of thousands of lives each year, and that something had gone wrong with the system of social welfare.[7]

The report argued that the National Health Service was not to blame, for much of the problem lay with social and economic factors beyond its influence. A call was made for more research and information on the problem, together with radical improvement of the material conditions of society's poorer groups. Here, however, it could only suggest more of the same. About half of its recommendation related to the delivery of care, while the rest sought improvements in living standards through increases in child benefit, maternity grants, disability allowances, provision for infant care, free school meals, housing grants and so on.

The report did not find favour with the Conservative Government, which declined to grant it even the usual publication through Her Majesty's Stationery Office. The Secretary of State calculated that the extra tax burden imposed by the recommendations would amount to more than £2 billion per year, more than the country could afford in the economic climate at that time. He was also wholly unconvinced that the effectiveness of what was being proposed was established. Thus the review and its recommendations were dismissed and the matter was left unattended. Sir George Young, the then Under-Secretary of State for Health and Security, saw progress being made by encouraging health education (first stressed in the Dawson report of 1920), personal responsibility for health (going back even further to 19th century notions), and encouraging voluntary organisations (an approach known to lead to disorganisation and inefficiency, as during the inter-war years).[49] Yet in a way the Government was right to be suspicious of the report's recommendations. Where was the evidence

from past experience that they would work?

Conclusions

Eighty years is more than long enough to conclude from Britain's vital statistics that the nation's system of personal social security and health care has failed to achieve its primary objectives. Social class differences in death rates, as measured by their SMR's, are much the same today as they were in the 1920's. This is because relative shortfalls in health are fundamentally inseparable from shortfalls in material wealth. Britain's ever increasingly complex system of taxation of wages and interest (here used in the classical sense of the returns to capital) has largely failed to redistribute wealth from the richer to the poorer sectors of society, and its national health service has been unable to protect the materially deprived from the consequent adverse effects on their health. Looking back to the origins of the welfare system, we can see how between 1890-1910 there was a great debate about the proper source of public revenue to pay for the programme of personal social services that was in its embryonic stages at that time. One school promoted the taxation of wages and interest; the other wished to collect the economic rent of land for this purpose. The former emerged victorious but, as we now see, to the detriment of the health of the nation. The vast accumulation of wealth and general improvement in the standard of living during the 20th century has not been accompanied by any improvement in the shortfall of health among the lower social classes. We must therefore look again at the proposals of those who sought to reap the site value of the land to ensure a greater equity in the distribution of the nation's wealth for the public good.