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ARTICLE

What is a ‘National’ ‘Health’ ‘Service’? A keyword analysis of policy documents leading to the formation of the UK NHS

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Abstract

This paper explores the keywords of ‘National’, ‘Health’ and ‘Service’ in the road to the NHS in 1948. It uses a form of Qualitative Content Analysis to analyse key documents in the period leading to the ‘Appointed Day’ when the NHS was created in 1948. In terms of ‘national’, most documents favoured Local Authorities, with ‘National’ coming rather late in the day. For ‘health’, most of the documents ‘talk’ of a broad or ‘positive’ health, but they lack any specific details, and seem to focus on a narrower curative medical service. Finally, most proposals relating to ‘service’ are based on insurance and a ‘90% service’, with the free and universal (100%) service arriving rather late in the period. Clearly, the three keywords could be combined in many ways, resulting in many possible types of NHS. However, bringing them together suggests that it was probably only with Beveridge onwards that the three keywords of national, health and service (citizenship) combined to form Bevan’s NHS.

Keywords: origins and methodology

1. Introduction

The UK ‘National Health Service’ (NHS) is well known across the world, but the meanings of the three constituent terms of ‘national’, ‘health’ and ‘service’ are far from self-evident. As these terms are widely used but poorly understood, there is a need to explore and unravel ascribed meanings and to understand how they change over time. This paper begins this process through an exploration of the road to the formation of the NHS, focusing on the arguments before 1948 as to why the NHS was needed. We approach this by means of ‘keywords’ (Williams, 1983 [1976]). The main aim of this paper is therefore to explore how the keywords of ‘National’, ‘Health’ and ‘Service’ were used in policy documents in the road to the NHS in 1948.

In 1976 the Welsh cultural theorist, Raymond Williams, published ‘Keywords: A vocabulary of culture’ (Williams, 1983 [1976]). The original 1976 text included 110 keywords, with a further 21 added later (Williams, 1983 [1976]) where he sought to provide ‘a record of an inquiry into a vocabulary’ (p. 15). The first step in this was identifying any dictionary definitions (e.g. pp. 13, 17). However, Williams notes that for some words, ‘especially for those which involve ideas and values, it is not only an impossible but an irrelevant procedure’ as dictionaries often focus solely on current meanings. He stressed the need to go beyond current meanings to historical dictionaries, and to essays in historical and contemporary semantics, taking us quite beyond the range of ‘proper meaning’, ‘we find a history and complexity of meanings; conscious changes,

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or consciously different uses; innovation, obsolescence, specialization, extension, overlap, transfer; or changes which are masked by a nominal continuity so that words which seem to have been there for centuries, with continuous generally meanings, have come in fact to express radically different or radically variable, yet sometimes hardly noticed, meanings and implications of meaning' (p. 17).

Williams also sets out some theoretical considerations. First, it is common practice to speak of the 'proper' or 'strict' meaning of a word by reference to its origins. However, while the original meanings of words are always interesting, for Williams their subsequent variation is more interesting (pp. 20–21). The emphasis of his analysis 'is deliberately social and historical' (p. 21). Second, it is important to examine interrelated or interconnected words (p. 22). Finally, the meaning of words depends on their actual contexts, although the problem of meaning can never be wholly dissolved into context (p. 22). Both meanings and relationships are typically diverse and variable, within the structures of particular social orders and the processes of social and historical change. He therefore aimed to show that 'some important social and historical processes occur within language, in ways which indicate how integral the problems of meanings and relationships really are' (p. 22). In short, 'to study both particular and relational meanings, then, in different actual speakers and writers, and in and through historical time, is a deliberate choice' (p. 23). Highmore (2022) notes that the idea that some words are 'keywords' is a central analytic belief within Cultural Studies, but what is less clear is how keywords should be selected, and then how analyses should proceed.

The 'Keywords Project' (<https://keywords.pitt.edu/whatis.html>) sets out some criteria regarding which words may be 'keywords'. A keyword is likely, for example, to be:

- Currently used;
- Polysemous (vague, or a 'wide word');
- Categorical (relatively abstract names to designate general practices, theories or standards of judgment);
- Actively contested (in the public domain, rather than simply in academic, technical or professional debates); and
- Part of a cluster of interrelated words which typically co-occur

Williams (1983 [1976]) selected his keywords from the domain of culture, while our keywords are selected from the domain of welfare state policy and politics. Notwithstanding this, the 'National Health Service' would appear to meet the above criteria for designation as a keyword.

Moran (2021: 2) outlines 'keywords-as-methodology' to show 'the whole way in which language change generally, and meaning change specifically, forms part of and provides insight into the nature of social and cultural transformation.' She writes that in practical terms, this means identifying the period in which the meaning change takes place, and then searching catalogues, magazines, books, manifestos, political and policy documents, corporate and institutional literature, new and traditional media, and more, for evidence of transitional, emergent and consolidating senses, noting who used the keyword, in what context, and with what aims and effects.

In this paper we use a form of Qualitative Content Analysis (Drisko and Maschi, 2016) to explore Keywords in the key documents in the period leading to the 'Appointed Day' when the NHS was created in 1948. These include a mixture of documents from government, political party, interest group, civil service, and Parliamentary Hansard (see Table 1, below).

We use a deductive (rather than inductive) approach to Qualitative Content Analysis, where keywords (i.e. 'NHS') are derived from the interest of researchers. Similarly, we focus on latent (rather than manifest) Qualitative Content Analysis, which refers to the process of interpretation of content, or discovering underlying meanings of the words or the content. In addition to keywords, we draw on connotative codes, which are based not on explicit words but on the overall or symbolic meaning of phrases or passages. For example, we search for 'health' and cognate terms

Table 1. Summary of sources with reference to the keywords

Source	National	Health	Service
Minority Report of the Royal Commission on the Poor Laws (1904–1909)	Local	Medical	Citizen
National Health Insurance Act (1911)	National	Primary Medical	Insurance
Dawson Report (1920)	National?	Health	?
Local Government Act (1929)	Local	Health	Citizen
Labour Party (1934)	Local	Health	Citizen
PEP (1937)	Regional/National?	Health	Insurance
BMA (1938) A General Medical Service for the Nation;	National	Medical	Insurance
Emergency Hospital Service	National	Hospital	Citizen
Emergency Medical Service	National	Medical	Citizen
Brown (1941)	National	Hospital	Citizen (but not free)
Beveridge Report (1942)	National	Health	Citizen
Draft Interim Report MPC 1942	National	Health	Insurance
Draft Interim Report MPR 1942	National	Health	Citizen
Labour Party (1943)	‘National’ (but local)	Health	Citizen
Willink White Paper (1944)	National	Health	Citizen
Bevan NHS Act (1946)	National	Health	Citizen
Appointed Day (1948)	National	Health	Citizen

such as illness in the documents. After identifying the sentence containing the term, we examine the surrounding sentences, until the document moves to a different issue.

As Williams (1983 [1976]) often did, we take the Oxford English Dictionary (OED) as our starting point. We first set out the relevant definitions of our three keywords from the OED, and then move to a wider discussion of the terms.

1.1 National (adjective)

- (1) relating to or characteristic of a nation.
- (2) owned, controlled, or financially supported by the state.

The first Keyword ‘national’ illustrates Williams’ (1983 [1976]) caution against taking the dictionary as a starting point, as the above definition spills over into notions of ‘service’ (discussed below) but without identifying the distinctively national elements of state ownership, control and support. In other words, whilst the first half of the definition identifies the ‘nation’, the second fails to differentiate the national from the local. This is problematic as a service can cover the nation but can be managed at the national or the local level. The term ‘national’ in public administration terms tends to relate more to national versus local control, or nationalisation versus municipalisation. Powell (1998) sets out three criteria that distinguish national from local services. First, in a national service there should be little autonomy and no democratic input at local levels. Second, there should be national as opposed to local funding. Third, central control and funding should lead to provision which is equitable according to centrally determined standards. In short, geographical location should make no difference to contribution or benefit, as the aim of a truly national service would be to make geography irrelevant.

The second element of the definition appears to focus on ‘nationalisation’, in the sense of whether a service is owned, controlled, or financed by the state. This echoes the ‘mixed economy of welfare’ three-dimensional account of ownership, finance and regulation (e.g. Powell, 2019). It highlights issues such as whether health services should be owned by the voluntary sector (i.e. ‘voluntary hospitals’) rather than the state, but is unclear whether this is the national or local state (nationalisation or municipalisation, below). Moreover, state finance relates to ‘decommodification’ or services free at the point of delivery (also discussed below). Our analysis will therefore explore ‘National’ in the sense of the first element of the dictionary definition (i.e. national versus local), and ‘nationalisation’, in the sense of whether a service is owned, controlled or financed by the state is explored in terms of ‘Service’ (below).

We recognise two further problems. First, it can be argued that the N for national in the NHS might be more suitably represented by S for state as this is arguably more relevant (an association of people characterised by formal institutions of government, including laws; permanent territorial boundaries; and sovereignty) than Nation (a group of people with a common language, history, culture, and (usually) geographic territory). Second, the documents are sometimes not fully clear in which nation or state they are referring to. For example, the Dawson Report (Ministry of Health, 1920) refers to England (with a separate report for Wales), MPC (1942) includes Scotland, but treats Wales as ‘England and Wales’, while MPR (1942) briefly discusses that Scotland and Wales requires special consideration. While many people think of the British NHS, much legislation including the Acts of creation refer separately to ‘England and Wales’ and ‘Scotland’, and that some of the main issues, institutions and policies in the period before the NHS were different (Stewart, 2003; Merrick, 2008).

2. Health (noun)

- (1) the state of being free from illness or injury.
- (2) a person’s mental or physical condition.

In 1948, the same year as the formation of the British NHS, the constitution of the World Health Organization (WHO) defined health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’. As Larsen (2022) notes, this clearly emphasised the positive rather than the negative aspects of health, and moved public health ideas about social and ‘socialized’ medicine from the fringes to the centre of health debates. We explore whether health is understood in a broader, positive or narrower, negative sense, and the implications of this for debates as to the role of the NHS in providing curative care, for example in hospitals, or preventive care in the community.

3. Service (noun)

- (1) the action or process of serving; an act of assistance.
- (2) a system supplying a public need such as transport, or utilities such as electricity and water; a public department or organisation run by the state: the probation service.

4. (Verb)

- (1) perform routine maintenance or repair work on (a vehicle or machine).
- (2) provide a service or services for.

This is perhaps the most polysemous of the three keywords. One meaning, which will not be discussed further below, relates to the ‘honorary’ nature of consultant staff in the voluntary hospitals as opposed to the salaried and hierarchical Medical Superintendent model of many municipal hospitals (eg Willcocks, 1967; Honigsbaum, 1979, 1989). In this sense, the traditional conception of the voluntary hospital was underpinned by donations of both finance and labour.

The noun seems to focus on ‘public need’ rather than ‘private want’ and links to the national element (above) in stressing a public department or organisation run by the state. It suggests that ‘public need’ should be satisfied by a state service distributed according to need rather than a private service based on profit or ability to pay. This implies a public sector superiority, perhaps due to the altruism of the ‘public sector ethos’, or ‘knightly behaviour’ (see e.g. Le Grand, 2014). The verb has resonances with Klein’s (2013: Ch. 11) discussion of the NHS as church versus garage, with ‘garage’ words (consumerism, responsiveness, demand, choice, contract, pluralistic, adaptability) distinct from ‘church’ words (paternalism, planning, need, priorities, trust, universalistic, stability). This keyword is perhaps best explored in terms of the NHS principles of being free at the point of delivery, universal and equitable (e.g. Powell, 1997). Put simply, it links to whether the service is available as a right of citizenship, with all covered by national social citizenship, or if coverage should be restricted to only part of the nation in the form of insurance coverage or income limits. This has been eloquently discussed by the creator of the NHS, Aneurin Bevan, in his text ‘In Place of Fear’ (Bevan, 1978; see also Powell, 1997). Bevan (1978: 100–104) discussed and rejected different forms of insurance in favour of progressive national taxation, as ‘personal contributory basis was peculiarly inappropriate to a national health service’ (p. 100).

5. Chronology of twentieth century documents

Having considered the dictionary definition, and its apparent limitations as a foundation for study of the keywords ‘National’, ‘Health’ and ‘Service’, this section examines the main pre-NHS documents chronologically before exploring them thematically in the following section. The beginning of the long road towards the NHS has been located in very different places including the voluntary hospitals, the County Asylums Act 1808, the New Poor Law of 1834, the National Health Insurance (NHI) Act of 1911, and the first Public Health Act of 1848 (e.g. Webster, 1988). As it would be difficult to cover every document in the long road to the NHS, we confine our analysis to the first half of the Twentieth Century and focus on official documents from governments and commissions set up by government, and medical and political interest groups, which were the major interests generally considered to have shaped the NHS (e.g. Willcocks, 1967; Honigsbaum, 1979, 1989; Webster, 1988). These are intended to be a ‘population’ (rather than a sample) of the most important documents. There are more documents from Labour than the Conservatives for two main reasons. First, the Conservatives were in government (as governing party or coalition partner) for most of the period, and so Conservatives’ views were expressed in official government rather than party political documents. Second, as it was the 1945 Labour government that created the NHS, we have focused on Labour’s evolving views.

The Royal Commission on the Poor Laws (1904–1909) produced a Minority and Majority Report. While both agreed that local authorities should take over the functions of the Poor Law, the Minority Report advocated ‘administrative specialisation’ with separate departments (e.g. public health) dealing with separate problems. The Minority Report also advocated for the integration of public health and poor law health services into ‘one united Public Medical Service’ (p. 886). This was to be established ‘on the lines of scientific prevention of disease and treatment, to be based on Public Health rather than upon Poor Law principles’ (p. 887). Fraser (2003: 175–6) observed that while ‘never can so important a Royal Commission have produced so little in the way of immediate action’, the Minority Report ‘anticipated much of the modern Welfare State’ (cf Jones, 2000: 79).

In the short term, the introduction of National Insurance in 1911 by the Liberal government rendered both the Majority and Minority Reports redundant, with the Liberal government instead introducing national insurance for manual workers between the ages of 16 and 70 earning less than £250 a year and non-manual workers earning less than £160 a year were required to contribute 4d a week (with the employer adding 3d and the state adding 2d) in return for

being able to see a ‘panel doctor’ (GP, or primary care doctor) and receive sickness benefit of 10s a week (Jones, 2000; Fraser, 2003).

The Ministry of Health was created in 1919. A ‘Consultative Council’, chaired by Lord Dawson, was asked:

‘To consider and make recommendations as to the scheme or schemes requisite for the systematised provision of such forms of medical and allied services as should ... be available for the inhabitants of a given area.’

The resulting ‘Interim Report on the Future Provision of Medical and Allied Services’ was published in 1920 (the ‘Dawson Report’, although there was never any final report). Although often regarded as a landmark report, this was vague in some respects. It made clear that preventive and curative medicine could not be separated on any sound principle, and any scheme of medical services must be brought together in close co-ordination. Moreover, any scheme of services had to be available for all classes of the community. However, the authors specified that in using the word ‘available’, they did not intend those services were to be free; ‘we exclude for the moment the question how they are to be paid for’. It differentiated between domiciliary and institutional, and between individual and communal services.

The Dawson report also proposed Health Centres where various medical services, preventive and curative, would be brought together in one organisation. The domiciliary services of a given district would be based on a Primary Health Centre. A group of Primary Health Centres should in turn be linked with a Secondary Health Centre. Secondary Health Centres should in turn be linked with a Teaching Hospital having a Medical School.

The Consultative Council seemed to be divided on several issues. Some members considered that curative services at Health Centres should be provided by the Health Authority free of charge to the individual patient. However, the majority of the members believed that this would impose a heavy burden on public funds. The Report stated that preventive services must of necessity be publicly provided: their relation to the individual is less obvious and personal. On the other hand, illness is a direct personal concern, and experience has shown that patients tend to be willing to make some contribution towards the cost of its treatment. It recommended that standard charges be made in the public wards and for other curative services, though this might vary in different parts of the country. Such charges would more often be met by some method of insurance.

It continued that curative and preventive services should be brought together in close co-ordination under a single Health Authority for each area. However, a new type of Health Authority would be required, as existing methods of health administration would not secure this essential condition. Some members favoured a Statutory Committee of an existing Local Authority, whereas others favoured the establishment of an ad hoc independent body for the purpose of administering health services alone. The Committee preferred to defer any final expression of opinion on this matter.

The Local Government Act 1929 in some ways drew on the Minority Report of 1929 (above) in that it passed administration of the Poor Laws to the major local authorities, allowing them to ‘appropriate’ facilities so that they would be administered by the local authority’s ‘public health’ rather than its ‘public assistance’ committee. Although this might sound like a minor symbolic change, it allowed the local Medical Officer of Health to supervise and improve. The intention was to develop municipal medicine, taking facilities away from the stigma of the Poor Laws (Levene *et al.*, 2011).

The PEP Health Service Study (1937) claimed to be the first attempt to show how all health services, preventive, curative, environmental and ancillary, work and fit together. PEP described itself as ‘an independent non party group’. Earwicker (1982) considers that the report’s recommendations are unoriginal, even dull, and seemed to have been inhibited by PEP’s prior claim

to impartiality. The Report discussed the relative merits and limitations of narrow and broad definitions of 'health services'. Narrow definitions were seen as making the common mistake of using health services as a synonym for 'medical services'. However, broad definitions risked expanding the subject 'to an unmanageable extent 'covering 'all human activities which promote health, including, for example, labour management, pricing of food and clothing, housing and its location play, and the methods of using leisure.' The report authors argued for a balance between these two positions.

It set out the case against health insurance as a method of meeting the health and sickness needs of the people (pp. 211–213), arguing that medical services, like elementary education, should be free to all members of the community. Instead, the report examined alternative models for the creation of a comprehensive 'public medical service'. Somewhat paradoxically the report elsewhere appears to favour NHI, suggesting that 'the least burdensome way of raising the necessary sum would be through a more comprehensive scheme of contributory insurance'. NHI would be extended to cover dependants of the existing insured population, giving a more complete family medical service at an extra cost to contributors of 3d a week, with the State providing an equal sum, approximately £9 million. It argued for research focussing on medicine, but also on the social and economic causes of ill-health such as strain in factories, effects of excessive journeys to and from work, and weaknesses in the health services and how to remedy them.

Webster (1990) presents the case for 'reinventing Labour' in explaining the origins of the NHS, against what he regards as the dominant view foregrounding the role of medical and bureaucratic civil service leaders. The Labour Party set out its views on health care over a long period of time. It had long used the term 'complete state medical service', but the meaning of the term was not fully clear. While it was clear that services should be freely available to all, prescriptions regarding national, regional and local organisation appear to vary over time, and be subject to different interpretations. For example, Marwick (1967: 384–385) argues that Labour favoured basing services on local authorities as early as 1905, before calls for nationalisation were passed at Labour conferences in 1909 and 1910 (p. 386). The 1911 conference approved a demand for a state medical service which was a 'real medical service ... that would be applied to everybody' (p. 387). Marwick continues that policy documents of the 1920s stressed that services should be comprehensive, based on local authorities and free at the point of use, and that they also stressed the importance of 'health centres'. However, there was no significant legislative action during Labour's brief periods in office in 1924 and 1929–31. The year 1931 saw the creation of the 'Socialist Medical Association' which saw itself as intending to shape Labour policy. A period of austerity in the 1930s saw pragmatic and gradualist policy aims. For example, a document of 1934 stated that a state medical service should be free and universal, but this could only be achieved in stages, and could be built upon either the existing national health insurance scheme or existing local authority services (but favoured the latter). According to Marwick, the 1943 document 'National Service for Health' 'was the first policy statement to appreciate fully the dependence of social policy upon efficient local government, and instead of basing its proposed health service on existing local authorities, as all previous Labour schemes had suggested, it posulated a scheme based on regional authorities' (p. 399).

Earwicker (1982) provides a rather different account, arguing that the party's belief in the fundamental principle of a universal, comprehensive and free service was first established in 1919. According to Labour's policy statement on Curative and Preventive Services in 1919, the development of a municipal medical service provided the most suitable vehicle for attaining a national health service that was universal, comprehensive, free and democratically accountable to local citizens. Earwicker (1982) argues that the party's 1934 statement, 'For Socialism and Peace' was much the most radical it has ever adopted and was the first time that a clear preference for a municipal medical service had been endorsed by party conference. In April 1943, Labour published 'National Service for Health'. Earwicker (1982) claims that this document saw Labour accepting the principle of a salaried medical service for the first time. It repeated the

party's demand for a free, comprehensive universal service financed through rates and taxes, democratically controlled by a re-organised system of local government which would run the health centres and co-ordinate the dual hospital system. It should be noted that there were extensive debates within the Labour Party over the proposed state medical service. While the SMA seemed to exert a disproportionate influence in the party before 1945 (see Stewart, 1999), Bevan was not constrained by the SMA line over localism, which was perhaps stronger in their power bases in large urban centres such as London.

While the Labour party developed these proposals, there were a number of evolving and competing proposals from medical interest groups. The British Medical Association (BMA) (1930, 1938) report entitled 'A General Medical Service for the Nation' broadly favoured extending NHI to cover dependents, which would cover an estimated 90% of the population. The BMA was firmly opposed to a 'whole-time salaried Government service' and was largely silent on issues such as health centres. Webster (1990) notes that the health-centre idea and even group practice was ignored in the BMA reports of 1930 and 1938.

In August 1940, the BMA established the Medical Planning Commission with a membership of seventy-three leading physicians, some appointed by the Association, others by other medical organisations. In the *British Medical Journal* of 20 June 1942, the Commission presented a 'Draft Interim Report' as a basis for discussion and requesting feedback to the Commission. The stated aim was to 'provide a system of medical service directed towards the achievement of positive health, the prevention of disease and the relief of sickness' (p. 743). It set out three broad options for achieving these goals: development of the existing system; a whole time salaried medical service; and an intermediate scheme between the two.

The report proposed, as had the BMA in previous declarations, that the NHI scheme should be extended to the dependents of insured workers and that in addition to the services of a general practitioner, the insured worker and his dependents be provided with the services of specialists and consultants, both in the home and in hospital. It claimed that NHI has stood the test of time and has proved itself fundamentally sound, efficient, and capable of development. With such extension of coverage, it is estimated that 90% of the people of Great Britain would become eligible for the benefits of the insurance scheme.

The report favoured administration at the regional level, with 'Regional hospital councils' co-ordinating the existing dual system of hospitals. It strongly supported the idea of a service run from the centre and administered at regional level so as to minimise the role played by local authorities in the provision of health services. It proposed that the services provided in 'health centres' should be 'preventive and educational as well as curative.' The Regional Authorities should be required by statute to delegate the administration of hospital and other medical, health, and allied health services to a committee or committees, containing non-elected members with knowledge and experience of such matters, including an adequate representation of the medical profession.

It discussed 'health centres' but stated that 'there is much divergence of opinion' on their 'nature, scope and functions' (p. 748). Webster (1990) argues that the MPC Report went to the opposite extreme to the earlier BMA documents, making group practice central to the new conception of primary care, while detailed information about health centre practice constituted the dominant element in the report. He argues that this was largely due to active SMA intervention on the MPC, a point which ultimately proved politically embarrassing to the BMA and contributed to a backlash against the Commission.

A rival proposal was put forward by 'Medical Planning Research', published in the *'Lancet'* on 21 November 1942. This was the work of over 200 members, mainly doctors qualified less than 21 years, or others connected with the health services aged 45 or under. It discussed methods of payment, seeming to favour national taxation. However, it proposed a 'social security insurance contribution' in return for health care and benefits (including sickness benefits) graded according to income, purchased by 'stamps' and not exceeding 8% of income. The report was not fully clear on how non-wage earners would be covered.

The report then turned to discussion of administration or ‘running the show’. It discussed different methods such as national and local administration, concluding that ‘we are firmly of the opinion that the central authority of the national health service should be a corporate body and not a department of state directly under a minister of the Crown’ (p. 614). A ‘National Health Corporation’, with a board of governors similar to the BBC, should be created, and divided into about ten regions in England. While it stated that ‘preventive and restorative health services’ are all ‘A1 priorities’ (p. 601), little detail was provided. Similarly, although there was significant discussion of ‘health centres’, there was little detail beyond that these should ‘encourage an emphasis on health rather than sickness’ and ‘have an important part to play in health education by lecture and by individual instruction’ (p. 617).

According to Webster (1988, 1990), a more positive spirit of initiative took hold in the period 1936–42, but formative discussions concerning health service reform dragged on over a period of six years. The first episode in comprehensive planning extended over a few months from November 1936 to March 1937, when officials considered an extension of local authority specialist services. The next step was establishment of a formal ‘office conference’ on the development of the health services, though this held only a few meetings between February and June 1938.

The fear of forthcoming war focused attention on health care, with the Emergency Hospital Service or Emergency Medical Service (Titmuss, 1950), created as a temporary expedient, marked ‘a secular shift towards a nationally planned and rationalised health service’ (Webster, 1988: 22). Ernest Brown, the Minister of Health in the wartime Coalition government made a statement in Parliament committing the Government to the creation of a comprehensive ‘National hospital service’ (Hansard, 1941). A duty was laid on the major local authorities to secure this in in close co-operation with the voluntary agencies, but it would be necessary to design such a service by reference to areas substantially larger than those of individual local authorities. Brown reiterated the principle that in general patients should be called on to make a reasonable payment towards the cost whether through contributory schemes or otherwise. A Labour backbencher, Aneurin Bevan asked two questions, both including the word ‘repugnant’. First, ‘is it not a fact that the maintenance of voluntary hospitals and their subvention by public funds and flag-days is becoming increasingly repugnant to the conscience of the public, and has not the time arrived when we should have a hospitals’ scheme more in accord with civilised notions of organised society?’ Second, ‘does he realise that his present policy is repugnant to every Labour Minister on the bench – or ought to be?’

The Beveridge Report (1942) is often regarded as being a major step towards the NHS. For example, Earwicker (1982) characterises the Beveridge Report as ‘the Steamroller Effect’. The Report set out ‘Assumption B’ of ‘Comprehensive health and rehabilitation services’ (p. 158). This involves ‘a national health service for prevention and for cure of disease and disability by medical treatment’ covering ‘rehabilitation and fitting for employment by treatment which will be both medical and post-medical’. In contrast to the ‘90%’ service proposed by the BMA, the service would be ‘100%’ or universal. ‘If a contribution for medical treatment is included in the insurance contribution, contributions will cover not ninety per cent, of the population (the present insured persons and their dependants), as is assumed in the Draft Interim Report issued by the Medical Planning Commission, but one hundred per cent, of the population’ (p. 160).

In short, ‘restoration of a sick person to health is a duty of the State and the sick person, prior to any other consideration’ (p. 159). Whether or not payment towards the cost of the health service is included in the social insurance contribution, the service itself should:

- be organised, not by the Ministry concerned with social insurance, but by Departments responsible for the health of the people and for positive and preventive as well as curative measures;
- be provided where needed without contribution conditions in any individual case (p. 159).

The Report provided few details, stating that ‘Most of the problems of organisation of such a service fall outside the scope of the Report’ (p. 159). However, Beveridge considered the ‘minor question’ of ‘whether persons in receipt of disability benefit, on entering an institution, should be required to make any payment towards the cost of their board as ‘hotel expenses’ (p. 161).

The Ministry of Health slowly developed from a ‘national hospital plan’ (above) towards a ‘National Health Service’. After Henry Willink had replaced Ernest Brown as Minister of Health, the Ministry published a White Paper ‘A National Health Service’ in 1944. This was based on: ‘comprehensiveness, freedom of the individual, democratic responsibility and professional guidance’. The White Paper attempted to resolve the division between Coalition partners, although clearly leaning more towards the Conservatives than Labour. It attempted to integrate voluntary and municipal hospitals through Joint Boards. It appears as if the Beveridge Report forced the government’s hand in pushing towards a free service, but earlier radicalism on issues such as salaried GPs had been diluted in consultation with the medical profession (see Powell, 1994). As Earwicker (1982) puts it, this indicated the gulf that existed between the Coalition partners on health reform; it had become clear that the phrase ‘a comprehensive national health service’ meant different things to the two parties.

The 1945 General Election led to the first ever majority Labour government, with Aneurin Bevan appointed as Minister of Health. As Earwicker (1982: 302–3) notes, it was no simple process to translate Labour’s ideas on health policy into legislation. While the ambition of a universal, comprehensive and free National Health Service was generally agreed within the Labour movement, the means to achieve this aim was the subject of controversy.

Bevan quickly rejected much of Willink’s White Paper, but also departed from Labour’s traditional stress on local authorities, with his most important structural decision being to create a national hospital service based on appointed hospital authorities termed ‘Hospital Management Committees’. As Earwicker (1982: 314) pointed out, at a stroke, Bevan intended to deprive the municipalities of the central place they had occupied in successive Labour plans since 1919, contravening the letter and spirit of every Labour party policy document on health. This led to a debate in Cabinet between Bevan and Herbert Morrison, who argued in favour of local authorities. However, Earwicker considers that the gladiatorial tone of this Cabinet debate is misleading for the most striking thing about the encounters between Bevan and Morrison is the weakness of Morrison’s opposition. While it is probably true that most ministers would have preferred a municipal solution, they also recognised that because of opposition from medical interest groups Bevan’s solution was the only viable scheme in the circumstances. He continues that the end of the war and the run-down of the EMS presented Bevan with an opportunity to seize the basis of a national hospital system and take all hospitals into public ownership.

The Health Service Bill, published on 21 March 1946, went further than the 1944 White Paper (Ministry of Health 1944) in providing for a universal, comprehensive and free service. There was to be no limitations to NHS services based on ‘financial means, age, sex, employment or vocation, area of residence or insurance qualification’. It also modified the Willink’s White Paper proposals on prevention and rehabilitation by making these services ‘a duty where the Minister requires’ rather than must a general permissive power.

The Conservatives opposed the Bill on both Second and Third Reading in the House of Commons. For example, their Third Reading amendment was a sweeping rejection of the basis of the Bill which, they said, discouraged voluntary effort and association; it mutilates the structure of local government; it dangerously increases ministerial power and patronage; appropriates trust funds and benefactions in contempt of the wishes of the donors and subscribers; and undermines the freedom and independence of the medical profession to the detriment of the nation (see e.g. Earwicker, 1982).

The NHS Act established a ‘comprehensive health service to secure the improvement in the physical and mental health of the people ... and the prevention, diagnosis and treatment of illness’. This was the basis for the creation of the NHS on the ‘Appointed Day’ of 5 July 1948.

6. Discussion

This section draws on the historical documents to consider the changing meanings of the three keywords over time.

6.1 National

The ‘Public Medical Service’ of the Royal Commission on the Poor Laws was consistent with many other documents in that the ‘public’ service was to be based on Local Authorities (below). National Insurance in 1911 was indeed a national scheme where all paid the same flat rate contribution in return for a flat rate benefit. The Dawson Report of 1920 discussed a ‘new type’ of ‘single Health Authority for each area’ but was divided on whether this should be a Statutory Committee of an existing Local Authority or a new independent body for the purpose of administering health services alone. The Local Government Act 1929 was based on major Local Authorities, which was similar to evolving Labour Party policies based largely on municipal medicine. However, there are some differences in interpretation of Labour health documents over the period, including some references to nationalisation, reorganised or regional local government, and the existing Local Authorities (e.g. Marwick, 1967; Earwicker, 1982; Webster, 1990). Although the PEP Health Service Study (1937) set out the case against health insurance, it also appeared to favour extending the existing NHI scheme to dependents. This broadly fitted with schemes of the various medical interest groups, which tended to favour regional or national administration, so as to minimise the role played by local authorities in the provision of health services (e.g. BMA, 1930, 1938; MPC, 1942). However, the more radical MPR (1942) proposed a ‘social security insurance contribution’ administered by a central body, along the lines of the BBC.

The Emergency Hospital Service or Emergency Medical Service (Titmuss, 1950) of the Second World War showed that a nationally planned service was feasible. However, the ‘Brown statement’ of 1941 proposed basing the ‘national hospital service’ on the major local authorities, although some regional planning would also be required. The Beveridge Report (1942) provided few details of the administration of the ‘comprehensive’ health service but seemed to favour a universal or ‘100%’ service rather than a ‘90%’ service based on insurance contributions and organised by a central government Department. The wartime Conservative Minister of Health, Henry Willink, in his proposed ‘National Health Service’ attempted to integrate voluntary and municipal hospitals through Joint Boards.

However, after the 1945 General Election, Bevan rejected both Willink’s solution and Labour’s traditional stress on local authorities, with his decision to nationalise the hospitals under appointed Committees, but with national Parliamentary accountability. The ‘National’ part of the health service only really applied to the hospital element of the Tri-Partite system, with Family Practitioner Services under local and professionally dominated Executive Councils and local public health services remaining with Local Authorities. It can be argued that the service would be ‘national’ only if operated by central rather than local government, and offered to citizens as a right of national citizenship rather than on a contributory or insurance basis (see ‘service’ below; Bevan, 1978).

6.2 Health

Most of the documents discussed wider ‘health’, ‘positive health’ or a collective focus as opposed to narrower ‘medical’, ‘negative health’ or an individual curative focus, by stressing ‘prevention’ and public health. However, it is unclear what type of prevention was envisaged, and difficult to point to any concrete ‘preventive’ measures beyond an often-vague mention of ‘health centres’. The Minority Report of the Royal Commission on the Poor Laws stressed that services should be ‘on the lines of scientific prevention of disease’ and treatment, and based on Public Health rather than upon Poor Law principles’ (p. 887). However, National Insurance in 1911 simply aimed to get the breadwinner back to work as quickly as possible by giving access to ‘panel doctors’ and providing ‘sick pay’. The Dawson Report (1920) stated that preventive and curative medicine could not be separated and should be brought together in Health Centres.

The Local Government Act 1929 aimed to integrate preventive and curative services under the local Medical Officer of Health (Levene *et al.*, 2011). The PEP Health Service Study (1937) claimed to be ‘the first attempt to show how all the health services, preventive, curative, environmental and ancillary, work and fit together’. It rejected a narrow definition of ‘health services’ whilst cautioning against an unmanageable definition including ‘all human activities which promote to promote health’.

The Labour Party broadly stressed in many documents over the period the importance of preventive services, and came to view ‘Health Centres’ as central to that vision (e.g. Webster, 1990; Marwick, 1967; Earwicker, 1982). In contrast, documents from medical interest groups, notably the BMA, tended to focus on curative services, largely ignoring prevention and Health Centres (see e.g. Webster, 1990). However, the MPC (1942: 743) aimed to achieve ‘positive health’ and ‘the prevention of disease’ (p. 743), with services provided in Health Centres being preventive and educational as well as curative (see e.g. Webster, 1990). However, it acknowledged that ‘there is much divergence of opinion on the nature, scope and functions of a Health Centre’ (p. 748). As noted, the report by the rival MPR (1942: 601) stated that ‘preventive and restorative health services’ are all ‘A1 priorities’ (p. 601) but little detail was provided. Similarly, although there was significant discussion of ‘health centres’, which should ‘encourage an emphasis on health rather than sickness’ (p. 617), this appeared to be linked to ‘health education by lecture and by individual instruction’ (p. 617).

The Brown Plan of 1941 for the Coalition government focused on a ‘national hospital service’. The Beveridge Report (1942: 158) set out ‘Assumption B’ of ‘Comprehensive health and rehabilitation services’ which involved ‘a national health service for prevention and for cure of disease and disability by medical treatment’, covering rehabilitation and fitting for employment by treatment which will be both medical and post-medical. The central government Department should be responsible for ‘the health of the people and for positive and preventive as well as curative measures’ (p. 159).

Most of the discussion in the Willink White Paper of 1944 relates to personal or curative services, although it briefly discusses environmental and preventive services in school and industry. It proposed a trial on a wide scale of grouping medical practices in publicly provided health centres provided by local authorities. It noted that health, in its broadest sense, involved not only medical services but environmental factors such as housing, sanitation, conditions in school and at work, diet and nutrition, and economic security. While these are fundamental, they were not the subject of this particular paper, which is concerned exclusively with the direct services of personal health care and advice and treatment.

For the 1945 Labour government, Bevan strengthened Willink’s proposals for prevention and rehabilitation, making them a ‘duty’ rather than a general permissive power. Webster (1990) argued that health centres constituted a key element in Labour’s health-care policy. Bevan’s NHS Act of 1946 established a ‘comprehensive health service to secure the improvement in the physical and mental health of the people ... and the prevention, diagnosis and treatment of illness’.

6.3 Service

Proposals varied between services based on citizenship and insurance over time, with the free and universal (100%) service arriving rather late in the period. The Minority Report of the Royal Commission on the Poor Laws proposed ‘one united public medical service’ (p. 886). However, while treatment should not be limited by considerations of whether the patient can or should repay the cost, it should not involve the gratuitous provision of medical treatment for all applicants. In other words, there should be clear rules about chargeability and recovery of charges for all patients who are able to pay (p. 910). National Insurance in 1911 provided services for contributors. The 1920 Dawson Report suggested that services be available for all classes of the community but stressed that ‘available’ did not equate to services being free, with charges often met by some method of insurance. Municipal hospitals ‘appropriated’ after the Local Government Act

1929 were required to recover fees on a means-tested basis. However, this seems to have been leniently applied, with some local authorities in effect providing free care. It was estimated that overall local authorities recovered no more than 10% of their total hospital costs (Webster, 1988: 6).

The PEP Report of 1937 appeared to favour an extended scheme of contributory insurance, which was also broadly favoured by medical interest groups. The BMA proposals of 1930 and 1938 suggested extending NHI to cover dependents, which would cover an estimated 90% of the population. The MPR of 1942 generally agreed with this ‘90% solution’, while the MPR of 1942 suggested a ‘social security insurance contribution’. In contrast, the Labour Party had long favoured a free and universal service based on (local or national) citizenship (Marwick, 1967; Earwicker, 1982; Webster, 1990). The Brown Plan of 1941 suggested that hospital patients should make a reasonable payment towards the cost whether through contributory schemes or otherwise.

The pressure for a free and universal service seems to have been realised through the Beveridge Report of 1942 (Earwicker, 1982), but with a small caveat of ‘hotel expenses’ for hospitals. Both Willink’s 1944 and Bevan’s 1946 White Papers stressed a free and universal service. The 1944 ‘comprehensive health service’ wished to ensure that every person could receive personal health care should not depend on whether they can pay for them, while Bevan stressed ‘no limitations on availability’. He later argued that the ‘collective principle’ asserts that medical treatment was a ‘communal responsibility’ that should be made available to rich and poor alike in accordance to medical need alone, without charge: ‘no society can legitimately call itself civilized if a sick person is denied medical aid because of lack of means’ (Bevan, 1978: 99–100).

7. Conclusions

The main British health documents of the first half of the twentieth century leading to the formation of the NHS show the changing meanings of the three keywords over time. In terms of ‘national’, most documents, apart from those from medical interest groups, favoured Local Authorities. ‘National’ came rather late in the day, with the example of the EMS, and then Bevan’s NHS becoming ‘national’ but only really the hospitals becoming nationalised. Turning to ‘health’, most of the documents ‘talk’ of a broad or ‘positive’ health, but as they lack any specific details, seem to focus on a narrower curative medical service. However, some documents appear to indicate a wider focus by discussing public health and Health Centres. Finally, most proposals relating to ‘service’ are based on insurance and a ‘90% service’, with the free and universal (100%) service arriving rather late in the period. Clearly, the three keywords could be combined in many ways, resulting in many possible types of NHS. However, bringing them together (e.g. Table 1) suggests that it was probably only with Beveridge onwards that the three keywords of national, health and service (citizenship) combined to form Bevan’s NHS.

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