Lessons from the History of British Health Policy

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The British Academy

Contents

Foreword

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The views expressed in these contributions, including the report which follows, are those of the authors and do not represent the views of the British Academy.

Introduction: health policy histories – what, where, and who?

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Key messages

‘Health policy’ is a slippery concept. In Britain, since the establishment of the National Health Service, it has often come to be associated only with the NHS, but it has a longer running and wider history. Health policy both predates the NHS and goes beyond it.

In this introduction we set the chapters in this report in context by exploring some of the issues that run through the history of health policy in Britain.

We focus on five areas:
1. What was or is ‘health policy’?
2. Where was health policy made?
3. Who were the policymakers?
4. What were some of the persisting policy challenges?
5. What are the politics of health policy?

Introduction

Even the most casual observer of recent world events cannot fail to have noticed that health policy matters. In its early stages, the COVID-19 pandemic was a real-time experiment in rapid health policy development and implementation. Different countries and regions introduced various measures to stop the virus from spreading with wide-ranging and profound effects on peoples’ lives and livelihoods. As the pandemic wore on, the political, economic, and social consequences of such policies became more apparent. Although compliance with ‘lockdown’ measures remained high in the UK, and the majority of adults took up the offer of vaccination against COVID-19, the trade-offs at work within health policy became a topic of public debate.

COVID-19 was a novel virus, but many of the challenges it posed to health policymakers were not new. Dealing with outbreaks of infectious disease and protecting the health of the community was a concern for ancient civilisations just as it is today. Since at least the early nineteenth century, governments needed to balance the economic benefit of the free movement of goods and people with the accompanying danger of circulating disease. Health policy in any place and at any time was never solely about ‘health’ but needed to take into account a range of political, social, and economic considerations too. Indeed, ‘health policy’ is a slippery concept, made even more so by change and continuity over time.

In this report we aim to shed light on the shape-shifting nature of British health policy by considering the societal, cultural, political, and economic drivers of health policy over the last 175 years. The chapters analyse the changing nature and scope of health policy from the introduction of the Public Health Act in 1848 to the COVID-19 pandemic in 2020. They explore the development of health policy in the UK in four distinct phases. The first focuses on the period 1848-1919, beginning with the 1848 Public Health Act, and ending with the establishment of the Ministry of Health in 1919, when health policy making was pluralistic, with both local and central government playing a role. The second chapter picks up where the first left off, focusing on the years from 1919-1948, when the central state's role in health policy expanded. The third chapter concentrates on the time between 1948 and 1974, when health policy was primarily (although not solely) directed towards the establishment and development of the National Health Service (NHS). In the final chapter, which begins with the reorganisation of the NHS in 1974 and culminates with the COVID-19 pandemic, the proliferation of 'health policy' and the tensions between policymakers, politicians, and experts became even more prominent.

Taken together, these chapters chart the changing shape and scope of health policy in Britain over almost two centuries, but they also highlight some significant continuities and ongoing challenges. In this Introduction, we bring these together by posing five key questions. Firstly, what was or is 'health policy'? As should already be clear, there is no simple answer to this question, and it is also one that changes over time. Secondly, where was health policy made? The domains or spaces of health policy varied over time, but there was continuity in some areas too. Thirdly, who were the policymakers? How did this change or stay the same over time? Fourthly, what were some of the persisting policy challenges? Finally, we return to our beginning and consider the politics of health policy.

What is or was 'health policy'?

Determining the boundaries of any policy domain is challenging, but 'health policy' especially so. In part this is because 'health' is difficult to characterise. A much-cited definition of health comes from the World Health Organisation's founding constitution, issued in 1948. According to the constitution 'Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.'[1] But conceptions of health pre-date the WHO constitution and incorporate other elements. Western medicine has many roots and branches that include anatomy, physiology, epidemiology, biomedicine, and more social perspectives.[2]

'Public health' is equally hard to pin down. The concept has changed over time and place, but has two common elements. Firstly, public health concerns the health of the population, whole or collective. Secondly, public health encompasses interventions or practices aimed at protecting the health of the public.[3] Bacteriologist CEA Winslow's classic definition of public health from 1920 is still used today, albeit with modifications.[4] He said that public health is the 'science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organised community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organisation of medical and nursing service for the early diagnosis and preventive treatment of disease, and development of social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health.'[5]

1 *Constitution of the World Health Organisation*, (1948) [accessed 12/09/2023].
2 Conti, A.A. (2018), 'Historical evolution of the concept of health in Western medicine', *Acta Biomedica*, 89(3), pp. 352-354.
3 Mold, A., Clark, P., Millward, G. and Payling, D. (2019), Placing the Public in Public Health in Post-war Britain, 1948-2012 (Palgrave Macmillan).
4 Berridge, V. (2016), Public Health: A Very Short Introduction (Oxford University Press), pp. 2-4.
5 Winslow, C.E.A. (1920), 'The untilled fields of public health', Science, 51, pp. 23-33.

Given such all-encompassing concepts, it is perhaps unsurprising that analysts have also struggled to define 'health policy'. The author of one textbook on the topic notes that 'the task of defining health policy is difficult, largely because both 'health' and 'policy' are open to different interpretations'.[6] Another remarks that, 'health policy means different things to different people'.[7] Health policy is a 'chameleon concept'.[8]

Nonetheless, there have been various attempts to give shape to this amorphous concept. A commonly cited definition of health policy is attributed to the WHO: 'Health policy refers to decisions, plans, and actions that are undertaken to achieve specific healthcare goals within a society.'[9] This broad definition sets out the general domain, but tells us little about how health policy is operationalised. It also assumes a deterministic role for policy, which is not always the way it is made or works out in practice. In practice, the boundaries of health policy are often narrowed. 'Most nation states have taken "health policy" to mean "medical care policy."'[10] This is perhaps especially the case in Britain since 1948, as the NHS came to dominate health policy and peoples' perceptions of it. Some writers on British health policy simply assume it means the NHS.[11]

Health policy may often be concerned with health services, but the broader ramifications of population health and the determinants of this also come into play. Lawrence Gostin, writing from an activist perspective, suggests that the goal of health policy is to protect and promote the health of individuals and the community. As population health, good or otherwise, is underpinned by a whole host of economic, social, cultural, technological, and environmental factors 'health policy' inevitably bleeds into other areas of government and public policy. As Buse, Mays and Walt note, health policy may encompass the actions of organisations that are not formally part of the health system, such as other government departments like the Ministry of Transport, and commercial actors, such as the food, tobacco or pharmaceutical industries.[12] Health, as the development of the 'healthy public policy' movement in the 1980s articulated, is embedded within every policy making domain whether it is acknowledged or not. The term 'health policy' assumes an overarching framework and a defined area, but in practice there are different arenas of policy within health policy with their own traditions and influences. Disability policy for example, is worlds away from the way in which illegal drug policy is made.

There is a danger then, that health policy is everything and everywhere, making the task of analysing its parameters, let alone how it might have changed over time, impossible. As the chronology provided at the end of this report demonstrates, a lot has happened in British health policy since the mid-nineteenth century, and not all of it falls within what might be strictly thought of as health policy. No analysis of health policy in this period could ever be comprehensive not just because so much has happened, but also because determining what that 'much' consists of is a moving target. Instead, the authors of the chapters in this report probe the boundaries of 'health policy' within their period, highlighting the dominant concerns, issues, and actors, as well as interrogating where health policy was predominately being made. Our approach focusses on history, although we recognise that there is also a tradition of writing about policy making from the political science perspective. The insights from that perspective are valuable and have been drawn upon for example with the concept of 'policy communities', or 'policy windows'.[13]

6 Baggott, R. (2016), *Understanding Health Policy* (The Policy Press), p. 1.

7 Walt, G. (1994), *Health Policy. An Introduction to Process and Power* (Zed Books), p. 1.

8 Exworthy, M., Peckham, S., Powell, M. and Ham, A. (2012), *Shaping health policy case study methods and analysis* (The Policy Press), p. 10.

9 The exact origin and location of this widely cited definition is hard to trace. This is the link everyone references, but that link no longer works or rather takes you to a different page. Nonetheless, the frequency of this citation suggests that this is a useful definition, even if its precise origin is unclear.

10 Navarro, V. (2007), 'What is a national health policy?' International Journal of Social Determinants of Health and Health Services, 37(1), p. 1.

11 Ham, C. (1992), *Health Policy in Britain. The Politics and Organisation of the National Health Service*, 3rd edn. (Macmillan). The sixth edition in 2009 had dropped the subtitle but the content of the book was still NHS focussed; Klein, R. (2013), *The New Politics of the NHS: From Creation to Reinvention*, 7th edn. (CRC press).

12 Buse, K., Mays, N. and Walt, G. (2005), *Making Health Policy* (Open University Press), pp. 6-7.

13 A useful overview of key policy making theories is provided by Cairney, P. (2019), *Understanding Public Policy: Theories and Issues* (Red Globe Press, 2019).

Where was health policy made?

This report opens with an analysis of the period from 1848 onwards as it was in this era that central government had its first official body concerned with health – the General Board of Health. Yet, as Tom Crook points out in Chapter One, no central authority had overall control of health affairs throughout the rest of the nineteenth century. Local government and local officials were a vital part of health policy making. The creation of the Ministry of Health in 1919 marked the beginning of increasing centralisation of health policy in Britain. This went a step further in 1948 with the establishment of the NHS. The founding of a 'national' health service inevitably moved policymaking to the centre, and to central government. Despite this, studies have shown the National Health Service was not a centralised service and local initiatives and traditions persisted.[14] But the development of the NHS and changes in its configuration over time were often driven from the centre to the periphery. Health concerns, and thus health policy, were also dealt with in other branches of central government. Transport, the environment, housing, energy, social care, to say nothing of economic and fiscal policy, all had an impact, direct or otherwise on health policy.

None of this means, however, that local government and local agencies were unimportant. In specific domains, such as public health policy, local government held sway for most of the period in question. Public health was left out of the NHS in 1948, was brought into the NHS from 1974 to 2012, and then went back into local government following the Health and Social Care Act in 2013. Local concerns could also figure in specific policy areas, such as around the building of a new hospital or its proposed closure. Indeed, health facilities themselves, whether they were hospitals, clinics, GP surgeries or something else, were also places where policies were created, adapted, and enacted. Health policy was made in a variety of places and although central government may often have taken the lead from the mid twentieth century onwards, it did not act alone. In the period we look at here, the role in health policy of the devolved governments became important, as did that of the European Union during the period of Britain's membership. International bodies such as the World Health Organisation (WHO) also exercised an important influence on national governments. 'British' health policy was never made solely on these shores.

Who were the policymakers?

The various spaces of health policy were peopled by a wide cast of actors. Politicians, and especially the Minister of Health, acquired a more prominent role as time went on. The Minister of Health did not even sit in Cabinet between 1951 and 1968.[15] The position, however, became more important as health issues and their significance rose up the political agenda. As the role of the Minister changed, so too did that of civil servants. The Chief Medical Officer retained an important historic role within central government, in the variously named health department, with his (or her) own cadre of medical civil servants.[16] Officials were and remain vital to the design and implementation of health policy. Since at least the 1950s external experts of various kinds have been brought in to shape specific policies and wider agendas. Initially, these were academics including economists and social policy specialists, later, management consultants took on an increasingly important role.[17] From the 1970s there was an increased focus on the role of 'evidence' in policy making, and the evidence used tended to focus on quantitative disciplines such as health economics, epidemiology, modelling, and statistics.[18]

14 Gorsky, M. (2012),'"A top down centralized system"? The British National Health Service in the 1950s and 1960s', in McMinn, S. (ed.) *Bristol Medico-Historical Society Proceedings, Volume Five (B) 2005-08* (Bristol Medico-Historical Society) pp. 94-106.

15 Webster, C. (2003), *The NHS a Political History* (Oxford University Press), p. 35.

16 Sheard, S. and Donaldson, L. (2018), *The Nation's Doctor: The Role of the Chief Medical Officer 1855-1998* (CRC Press).

17 Begley, P. and Sheard, S. (2019), 'McKinsey and the 'Tripartite Monster': The Role of Management Consultants in the 1974 NHS Reorganisation', *Medical History*, 63(4), pp. 390-410.

18 Berridge, V. (2005), *Making Health Policy. Networks in Research and Policy after 1945* (Rodopi).

Away from the corridors of Whitehall, other actors were also significant. Health professionals, and especially doctors, were crucial to the success or otherwise of many policy initiatives. At the local level, Medical Officers of Health (MOHs) were a key part not only of service delivery, but also of its design and implementation, from the mid nineteenth century until the mid-1970s. At the national level, representative bodies like the British Medical Association could stymie policies as well as champion them, just as it nearly did with the establishment of the NHS itself.

The role of non-health professionals, and especially voluntary organisations, should also not be overlooked. Voluntary organisations like the Friendly Societies were an integral part of the pre-NHS health system.[19] Friendly Societies were mutual aid organisations that provided financial and social support to largely working-class subscribers, including sickness insurance which paid for healthcare. The service providing role of charities continued in some areas even after the establishment of the NHS, as did their lobbying and policy making dimension.[20] Voluntary organisations representing the interests of patients, for example, became increasingly prominent from the 1960s onwards.[21] New style activist groups such as Action on Smoking and Health (ASH) brought media focussed campaigning to the fore.[22] Some groups became incorporated within various branches of the health system, but others remained outside it. Quangos, or quasi-governmental bodies, became a feature in the later decades of the twentieth century. These had various functions, from the specific to the wider ranging, and could operate as a way to deal with contentious issues (such as who should get access to a particular drug) in a way that seemed to be above politics.

The health policy arena was always heavily peopled, although it appears to have become increasingly overcrowded in more recent years. Political scientists have drawn attention to the role of 'policy communities' focussing on the networks which operate in particular policy areas between government, civil service, and pressure group networks. Policy communities and 'issue networks' have their own membership dependent on the policy area. Nor should the role of 'industry' and trade associations within these networks be forgotten, a sometimes controversial aspect.

What were some of the persisting policy challenges?

Despite the best efforts of this diverse cast of actors, British health policy was beset with some persistent challenges. The changing nature of population health over the last two centuries presented its own difficulties, as policymakers and service providers adjusted to the decline of infectious disease, the rise of chronic conditions and an aging population. Perhaps the most persistent challenge was how to finance health services. Whether funds came from local rate payers, Friendly Society subscribers, National Insurance, general taxation, or the individual themselves, resourcing healthcare was a permanent headache. Costs seemed to only ever increase, but these were rarely met with a willingness to foot the bill. Determining how and where money should be spent was contentious, but also seemed to go hand in hand with inequalities in health and health service provision. Variation in access to and the quality of services was a feature of the pre-NHS system, and despite its architects' greatest hopes, inequalities did not disappear with the coming of the NHS.[23]

19 Gorsky, M. and Mohan, J. with Willis, T. (2006), *Mutualism and Health Care: British Hospital Contributory Schemes in the Twentieth Century* (Manchester University Press).

20 Mold, A. and Berridge, V. (2010), *Voluntary Action and Illegal Drugs: Health and Society in Britain Since the 1960s* (Palgrave).

21 Mold, A. (2005), *Making the Patient-Consumer: Patient Organisations and Health Consumerism in Britain* (Manchester University Press).

22 Berridge, V. (2007), *Marketing Health: Smoking and the Discourse of Public Health in Britain, 1945-2000* (Oxford University Press).

23 Webster, C. (2003), 'Investigating Inequalities in Health Before Black' in Berridge, V. and Blume, S. (eds), *Poor Health. Social Inequality Before and After the Black Report* (Frank Cass), pp. 81-103.

Centralisation also failed to do away with another persistent challenge: how to organise health services. The patchwork of pre-NHS provision to some extent persisted through the early years of the NHS. In later years, and certainly since the mid-1970s, the NHS has undergone a permanent revolution, with successive periods of reform and reorganisation.[24] At the same time, the remit of health services was also in flux and in debt to its history. The issue of the boundary between health and social care predated the coming of the NHS and is rooted in the pre-NHS health system. British health policy persistently failed to deal adequately with the needs of the elderly, mentally ill, and disabled. Likewise, 'public health' has sat awkwardly alongside or within health systems and health policies. Despite being championed as the way to avoid many health problems, disease prevention and control has slipped down policymakers' list of priorities not only because it is difficult to achieve, but also because it has not figured strongly enough within the health system.

Health policy and health policymakers have also had to deal with resistance. This could take many forms, from the obstruction of local elites to the building of sewers or hospitals, to the opposition by doctors to the establishment of the NHS.[25] Individuals could also resist specific health policies as well, as, for instance, anti-vaccination sentiment from the nineteenth century to the present makes clear.

The politics of health policy

Resistance to health policy underscores the point that health policy never is, and never was, above politics. Nonetheless, there have been moments in time within the history of British health policy that have been more or less contentious. Making health policy requires resources, trade-offs and sometimes hard choices. As the cost of service provision increased, it was perhaps inevitable that health policy became more 'political', as politicians and the public wanted to know what their money was being spent on. The attention of the media to health issues was also a significant driver of the politicisation of health policy and media interest has significantly increased over time. Not only did health matters receive more scrutiny, but these could also be presented in a way that appealed to those with certain political interests.

Although health policy is less easily associated with specific 'left-wing' or 'right-wing' political policies compared to say, economic policy, the broad trajectory of British politics can be detected in the shape of its health policy. The liberalism of the nineteenth and early twentieth century, through to the social democracy of the mid twentieth century, and on to the neoliberalism of the 1980s onwards, all left their mark on health policy. These trends can be detected in the chapters in this collection, but so too can the more micro political shifts as particular policies (and policymakers) rose and fell.

Conclusion

The political dimension to health policy making in Britain over the last two centuries is just one of the many constants pointed to in the chapters in this report. Collectively, these deal not only with the history of health policy but also offer a set of powerful insights into the processes, problems, and practices of health policy. Drawing 'lessons' from such a history is always something of a movable feast. Nonetheless, these chapters offer a set of powerful insights into health policy in the past, that may speak to the present. Difficulties with implementation, variability, lack of clarity over who was in control, poor coordination of services, lack of resources, a proliferation of policy actors, and tensions between them, are not just historical problems, but contemporary ones too. This report may not provide many solutions, but by exposing the roots of ongoing issues, better policies may yet come to fruit.

[24] Baggott, R. (1994), 'Reforming the British Health Care System: A Permanent Revolution?', *Policy Studies*, 15(3), pp. 35-47.

[25] Crook, T. (2016), *Governing Systems: Modernity and the Making of Public Health in England, 1830-1910* (University of California Press); Seaton, A. (2015), 'Against the 'Sacred Cow': NHS Opposition and the Fellowship for Freedom in Medicine, 1948–72', *Twentieth Century British History* 26.3, pp. 424-449.

Chapter 1: British health policy, 1848-1919

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Key messages

The year 1848 witnessed the arrival of the first dedicated official home for health policy in Whitehall, the General Board of Health. It marked the advent of a new era of central supervision and accountability in the making and implementation of British health policy. Between 1871 and 1919 the key central office was the Local Government Board.

Throughout this period, health policy was always a plural formation, composed of a number of overlapping strands: sanitary reform and environmental health; industrial health and the health of children; state medicine and the control of infectious diseases; and welfare and health insurance.

This made for problems of institutional coordination and administrative clarity, however. The consolidated leadership of health policy proved elusive. No particular central authority enjoyed a bird's eye view of health policy across Britain as a whole.

The implementation of health policies was highly variable across time and space. This can be explained by a number of factors: the highly localized culture of administration; a pervasive commitment to economy; and active resistance from multiple groups, among them MPs, owners of capital, councillors, and members of the public.

These administrative problems should not obscure the considerable gains secured to the health outcomes for the British population. This, too, can be explained by a number of factors: the growing professionalization of health policy and its day-to-day implementation; the gradual accretion and refinement of permanent infrastructural and bureaucratic systems that set new standards of healthcare; and the scope for innovation and experimentation afforded by the relatively localized culture of administration.

1.1 Introduction

The overall health of the British population was in much better shape in 1919 compared to 1848. Almost all metrics attest to this, and the period is notable for a general decline in the relative mortality of infectious diseases. Average life expectancy increased from roughly 40 years to 50 and infant mortality declined considerably.[26] This was largely, if by no means wholly, a product of a range of policy initiatives. Historians commonly attribute these to the growth of the state, even an incipient welfare state, presaging the establishment of the NHS in 1948.[27]

[26] The two accounts which between them provide the most accessible overview of the effectiveness of health policy, construed broadly, are Wohl, A.S. (1983), *Endangered Lives: Public Health in Victorian Britain* (Methuen), and Cherry, S. (1996), *Medical Services and the Hospitals in Britain, 1860–1939* (Cambridge University Press).

[27] See, for example, Harris, B. (2004), *The Origins of the British Welfare State: Social Welfare in England and Wales, 1800–1945* (Palgrave Macmillan); Fraser, D. (2009), *The Evolution of the British Welfare State: A History of Social Policy since the Industrial Revolution*, 4th edn. (Palgrave Macmillan).

This kind of reading is not entirely without merit. The year 1848 is important precisely because it marks the arrival of the first dedicated official home for health policy in Whitehall: the General Board of Health (GBH), with responsibility for England and Wales. A similar central authority for Scotland was established in 1856. Other offices would follow, notably the Local Government Board (LGB) in 1871, which remained until 1919 and brought together the central administration of the poor laws and the sanitary functions of the GBH and its successor offices.[28] Scotland again established something similar in 1894. At the very least the state now exercised a degree of central oversight and supervision over health policy, and it did so equipped with the comprehensive vital statistics furnished by the General Register Office (GRO), earlier established in 1837.[29] Central funding of health-related policies also increased over time, in line with a broader expansion of civil expenditure.

It would be wrong, however, to grant too much importance to the role of the state. This is partly because the state was only one crucial agent among many. Above all, it risks attributing far too much cogency and purpose to what was always an intensely fraught, frustrated, and eclectic arena of governance—and it is precisely this that needs to be foregrounded if we wish to draw lessons from this critical juncture in the history of British health policy.

1.2 The many strands of health policy

One aspect of this is the need to recognise that health policy—not a term commonly used at the time—was an intrinsically plural formation, composed of a number of overlapping strands. Four of these might be highlighted. All have their roots in the period c. 1820–1850, when the combined effects of industrialisation and urbanisation were subject to unprecedented exposure and politicisation, both within parliament and beyond. All were principally concerned with the health of urban-industrial centres and their relatively young and mobile populations, and with good reason. Between 1801 and 1851, the British population increased from roughly 10.5 million to almost 21 million, and by mid-century just over half the population was living in towns or cities. During the 1820s alone the population of newly emerging industrial centres such as Bradford, Leeds, and Manchester grew by more than 40%. Such demographic pressures remained: by 1901, when the overall population stood at 48 million, over 70% were living in urban areas.

Sanitary reform and environmental health

Although it would last only a decade, the signal contribution of the GBH was to place sanitary engineering and general civic cleanliness at the heart of health policy.[30] Led by the energetic official Edwin Chadwick and equipped with a small band of central inspectors, the GBH's principal object was to promote the adoption of integrated, water-borne sewerage systems and urban drainage networks by local authorities, whether in the form of municipal corporations, specially constituted local boards of health, or, in London, the Metropolitan Board of Works (MBW, 1855–89).[31] It kick-started a long process of reshaping Britain's urban environment, both above and below ground, which was eventually completed under the reign of the LGB and steered at the local level by borough engineers and surveyors, who formed their own professional association in 1873. The outstanding achievement of mid-century was Joseph Bazalgette's main drainage scheme for the MBW, which mobilized over 1,300 miles of main sewers, eighty-two miles of intercepting sewers, and involved contracting over twenty civil

28 The GBH was succeeded by two bodies in 1858: the Local Government Act Office and the Medical Department of the Privy Council. Both were incorporated into the LGB. On the complexity of the institutional landscape of public health at the time, see Crook, T. (2016), *Governing Systems*.

29 Scotland established a General Register Office in 1854.

30 Hamlin, C. (1998), *Public Health and Social Justice in the Age of Chadwick: Britain, 1800-1854* (Cambridge University Press).

31 Strictly speaking, London was beyond the official reach of the GBH. Nonetheless, its consolidated sanitary administration, which began with the Metropolitan Commission of Sewers established in 1847, was fully exposed to the work of the GBH; and Chadwick himself was initially a member of the Metropolitan Commission.

engineering firms. Completed between 1859 and 1875, the basic premise was simple enough: to collect the human waste, industrial effluence, and rainwater that had previously gathered in cesspools or flowed into nearby rivers (from where drinking water had often been extracted) and transport it to outfall works where the sewage could be worked upon, before returning the (purified) water to rivers.

Other cities and towns adopted schemes of the same broad design, prompting a marked growth in local authority borrowing sanctioned by central officials for water, drainage, and sewerage systems. The amount borrowed expanded from roughly £11 million between 1848 and 1870 to almost £50 million between 1871 and 1891 under the LGB. This was by far the most technologically demanding aspect of health policy. It was not until the 1890s when attempts to put sewage to agricultural use were finally abandoned in favour of the more modest aim of treatment—of the sort practised today—thus sparing Britain's rivers and seashores of still further pollution.

The 1840s also witnessed the appearance of the first public baths, open to all classes. By 1914 there were more than 300 establishments, almost all run by local authorities. Other sanitary measures designed to enhance urban amenity included the provision of public parks and the replacement of church-side burial spaces with more spacious municipal cemeteries. Of more impact were two other facets of sanitary reform galvanized by the GBH and brought to fruition under the LGB. One of these was the improvement of housing standards, which carried forward work initially undertaken by philanthropic societies and paternalist employers in the 1830s and 1840s. The first national set of 'model' buildings byelaws appeared in 1858, followed by another under the LGB in 1877, covering all manner of variables, from the width of streets to the installation of water-closets. Byelaws affected only new-built homes and were thus effective only in the long-term. More immediate relief was found in powers granted by statute to local authorities to inspect common lodging houses (1851), ensure houses were connected to sewer mains (1866), and demolish inner-city slums (1868, 1875).[32]

The other key facet developed by the GBH was the regulation of 'nuisances'. Beginning in 1846, a succession of parliamentary acts (in 1848, 1855, 1866, and 1875) ensured that the term retained its capacious common law qualities by defining a 'nuisance' as any form of pollution or sanitary defect that was, or just might be, 'prejudicial to health'.[33] Meanwhile, sanitary inspectors were employed to police nuisances at the local level, and they were sufficiently numerous by the early 1880s to form their own professional association. Having first appeared in Liverpool and London in the 1840s, their appointment was made compulsory in 1872, giving rise, in major cities at least, to elaborate teams of roving officials. By the mid-1890s, Manchester, for example, was home to twenty-eight residential inspectors, four smoke inspectors, two food and meat inspectors, and six workshop inspectors.

Industrial health and the health of children

A further field of policymaking targeted the effects of industrialisation and the health of factory workers, which included children. This was partly a matter of attacking the pollution produced by factories. Some of this was managed under the nuisance regulations noted above. More specific interventions included the establishment of an alkali inspectorate under the Board of Trade in 1864 to help reduce the industrial release of acid gas (hydrogen chloride) into the atmosphere. Another was the 1876 Rivers Pollution Act and the subsequent setting up of regional conservancy boards, which gradually diminished the practice of allowing industrial effluence to flow into rivers. Working conditions and employment practices were also improved. A factory inspectorate, based at the Home Office, was set up in 1833 to monitor working conditions, while a succession of statutes slowly but surely restricted working hours and

32 Rodger, R. (1995), Housing in Urban Britain, 1780–1914 (Cambridge University Press).
33 See, for example, (1855), *Nuisances Removal and Diseases Prevention Consolidation and Amendment Act, 1855.*

the employment of children.[34] By 1870, legislation had barred children under 8 from all factories and workshops, reduced the hours of older children to six-and-a-half per day, and established a *de facto* sixty-hour week for all adult workers.

The advent of universal compulsory elementary education in the 1870s spurred further improvements in the health of children. This was principally because it provided an institutional environment where their health could be more closely observed and nurtured. This culminated in the provision of free, ratepayer funded school meals for poorer pupils in 1906 and the introduction of school medical inspections in 1908, overseen by a new department of the Board of Education.[35] At the same time, workers in heavy industry and factory employees were afforded further protections. Starting with the 1880 Employers' Liability Act, a series of parliamentary measures redressed imbalances in the legal responsibility for workplace accidents, shifting them in favour of employees and fostering a more rigorous safety culture. Targeted measures were also now directed towards specific work-related diseases, marking the birth of occupational health and deepening the earlier concern to enhance general working conditions.[36] In 1898, the Home Office appointed the nation's first Medical Inspector of Factories, while a more discriminating regulatory environment slowly took shape. The first substantive legislative intervention was the 1883 Factory Act, which tightly controlled the production of white lead; and many more would follow, among them an act of 1895, which required employers to report cases of anthrax, arsenic, and lead poisoning, and another in 1908, which banned the manufacture of white phosphorus matches.

State medicine and the control of infectious diseases

Complementing the above two areas was a set of prophylactic policies that mobilised the expertise of doctors, rather than engineers, architects or inspectors, and which, in one form or another, were more person-centred and that targeted the movement and exposure of individual bodies to particular infectious diseases.[37] It was an approach that was often promoted from mid-century under the label of 'state medicine' and its principal champions at the local level were Medical Officers of Health (MOHs), who formed a professional association in 1856. Like sanitary inspectors, they first appeared in major cities in the 1840s, before their appointment was made compulsory in 1872. By the 1880s they had become the principal directors of health policy at the local level, guiding the work of sanitary inspectors, submitting annual reports to the LGB and their local authority, and routinely liaising with councillors and other officials. Among the latter were borough engineers, as well as a new band of public analysts, appointed under the 1875 Sale of Food and Drugs Act, to undertake laboratory analysis of suspect food items identified by inspectors.

The two most striking instances of state medicine are smallpox vaccination and a series of Contagious Diseases Acts (CDAs) passed in the late 1860s.[38] In 1840, smallpox vaccination, administered via the poor law infrastructure, was provided for free at public, ratepayer expense, and then made compulsory in 1853 for infants up to three months of age. Further statutes in 1867 and 1871 tightened the administrative framework and extended the provisions to children under the age of fourteen. The CDAs allowed for the forcible detention of prostitutes to protect against the spread of venereal disease in the armed forces, and by the early 1870s they were in use in eighteen naval and garrison towns.

34 Pellew, J. (1982), *The Home Office, 1848-1914: From Clerks to Bureaucrats* (Heinemann Educational).

35 Harris, B. (1995), *The Health of the Schoolchild: A History of the School Medical Service in England and Wales* (Open University Press).

36 Bartrip, P.W.J. (2002), *The Home Office and the Dangerous Trades: Regulating Occupational Disease in Victorian and Edwardian Britain* (Rodopi).

37 Mooney, G. (2015), *Intrusive Interventions: Public Health, Domestic Space, and Infectious Disease Surveillance in England, 1840–1914* (University of Rochester Press).

38 Durbach, N. (2005), *Bodily Matters: The Anti-Vaccination Movement in England, 1853–1907* (Duke University Press); Walkowitz, J.D. (1980), *Prostitution and Victorian Society: Women, Class, and the State* (Cambridge University Press).

Both of the above were imagined as contributing to the 'stamping out' of infectious diseases. The key development in this respect, however, was the development of integrated, localised systems that combined three core practices—notification, isolation, and disinfection. This applied to a range of infectious diseases, chief among them cholera, typhoid, and typhus, as well as those which principally affected infants and children, such as smallpox, diphtheria, and scarlet fever. Although the process had begun under the GBH, it was during the reign of the LGB that Britain developed an alternative to the centuries-old practice of indiscriminate quarantine. Created in 1872, port sanitary authorities applied instead the so-called 'English system', based upon the close inspection of ships from infected or suspect ports, the hospital isolation of any individual cases, and the disinfection of any suspect goods or persons.[39] During the 1870s and 1880s similarly risk-averse, targeted systems began to develop inland. By the early 1900s, following a number of statutes (in 1866, 1875, 1889, 1893, and 1899), all towns and cities had MOH-led systems in place for the compulsory notification of infectious diseases, the compulsory isolation of the infected at ratepayer-funded isolation hospitals, and the cleansing of homes by specialist disinfection teams. The figures are striking: whereas there was only a handful of specialist facilities at mid-century, by 1914 there were some 755 borough- or county-based isolation hospitals, and more than 350 facilities dedicated to caring for those with smallpox.

Welfare and health insurance

A final area of health policy concerned popular access to doctors, medicines, and hospital care.[40] This was an especially eclectic arena of provision, though the professionalisation of medical practice, surgery, and nursing helped to raise standards of care, however they might be accessed. Traditionally, the poor law had provided public forms of medical relief to the destitute. Funded by local ratepayers, it was significantly reformed in 1834 with the advent of central supervision in the form of the Poor Law Commission (PLC) and freshly constituted boards of guardians, as well as efforts, which continued under the LGB, to restrict 'outdoor' relief and dispense help only to those who needed it most within workhouses.[41] These efforts meant that recipients of relief were increasingly the very young, very old or the disabled, and there was a gradual increase in the quality and specificity of the care they were afforded 'indoors'. The poor law medical service grew apace and by the end of the century it was employing over 4,000 local medical officers and 6,000 nurses in England and Wales.

Beyond the poor law, access to doctors and medicines was also provided by philanthropic and charitable organisations.[42] This assumed various forms, among them free dispensaries, orphanages, and voluntary hospitals funded by wealthy patrons. The latter were especially important: in 1911 they provided almost 54,000 hospital beds, out of a national total of roughly 180,000. This kind of provision was difficult to regulate, but from mid-century it was much better scrutinised, while attempts were made by bodies such as the Charity Organisation Society (established in 1869) to manage its reach and distribution, so as not to conflict with the workings of the poor law.

To the extent that there was a core policy in this area, it was the one inscribed in the punitive ethos of the poor law: simply that people should do all they could to provide for their own healthcare through participating in schemes that pooled resources and shared risks. Whether out of necessity or on principle, the majority of working people did just this, relying on a variety of institutions into which they made regular contributions in return for help as

39 Maglen, K. (2014), *The English System: Quarantine, Immigration and the Making of a Port Sanitary Zone* (Manchester University Press).

40 The best general narrative of this aspect of health policy remains Finlayson, G. (1994), *Citizen, State, and Social Welfare in Britain, 1830–1990* (Oxford University Press).

41 Kidd, A. (1999), *State, Society and the Poor in Nineteenth-Century England* (Palgrave Macmillan); Englander, D. (2013), *Poverty and Poor Law Reform in Nineteenth-Century Britain, 1834-1914: From Chadwick to Booth* (Routledge).

42 Cherry, *Medical Services and the Hospitals in Britain.*

and when required: doctors' clubs, work clubs, trade union schemes, and friendly societies, among others. Friendly societies were the most popular and after 1846 some degree of regulation and uniformity was secured through the office of a central registrar. By 1900 it is estimated that over four million friendly society members were eligible for medical care and nine million for sickness benefits.[43] Membership of 'mutual aid' schemes, however, was by no means universal, even among men with regular employment, forcing many families to rely on the poor law, temporary loans of some sort, or help from makeshift networks of neighbourhood support. It was precisely this problem that the first part of the 1911 National Insurance Act sought to address by introducing a compulsory system of contributions which incorporated payments from employees, employers, and the central state. Overseen by a Treasury-based insurance commission and administered by 'approved' friendly societies and other bodies, the act helped to provide some fourteen million workers with access to doctors, drugs, and hospital treatment, as well as modest sickness, disability, and maternity benefits.

1.3 The frustrations of health policy

The success of the above measures has already been noted: slowly, cumulatively, they helped to ensure better health outcomes for the majority of the population. Other factors played a part, notably improved standards of nutrition, while the rise in real wages experienced during the second half of the century enabled a growth in the domestic consumption of soap and disinfectants, which were vigorously promoted by their commercial manufacturers.[44] Nonetheless, there is no question that the policies outlined above played a decisive role.

It would be wrong, however, to attribute these policies to some kind of grand design or to the work of a singular administrative agent or force. Policies were formed and revised in a fitful fashion, according to all sorts of contingent prods and pushes. Global pandemics provided crucial impetus at times. Visitations of cholera in 1848–9 and 1853–4 added urgency to the sanitary agenda of the GBH; the brutal impact of so-called Spanish flu hastened the demise of the LGB in 1918–19, when it was replaced by a new Ministry of Health. At other times national outbreaks stimulated reform, as in the case of the smallpox vaccination regime. Periodic public panics were also in the mix, for instance those surrounding 'factory slavery' in the 1830s, slum housing in the 1880s, and urban 'degeneration' in the early 1900s. Governments, meanwhile, came and went, and with them ministers more or less disposed to reform.

Still more crucially, the above areas of policymaking had to contend with a series of recurrent problems and sources of frustration. All arose from the fact that the work of improving health involved a variety of agents, just indeed as it involved a variety of policy areas. All reflected a broad and enduring attachment among the governing elites—which we might loosely characterise as 'liberal'—to the primacy of local government, the authority of property and parliament, and a deterrent welfare (poor law) regime. Four systemic problems might be highlighted.

Co-ordination

One recurrent source of frustration was the absence of adequate institutional co-ordination and clarity. As noted above, Scotland was home to its own health bureaucracy, which reflected peculiar legal and administrative traditions, especially in relation to the relief of the poor.[45]

43 Cordery, S. (2003), *British Friendly Societies, 1750–1914* (Palgrave Macmillan).

44 There has been longstanding and significant debate about the causes of Britain's epidemiological transition during this time. The general consensus now, however, is that health policies played a key role, even if higher wages and better diets, among other factors, also played a part. See especially the interventions by Hardy, A. (1993), *The Epidemic Streets: Infectious Disease and the Rise of Preventive Medicine, 1856–1900* (Clarendon Press) and Szreter, S. (2005), *Health and Wealth: Studies in History and Policy* (University of Rochester Press).

45 Englander, *Poverty and Poor Law Reform*; Mitchison, R. (2002), 'Poor Relief and Health Care in 19th-century Scotland', in Grell, O.P., Cunningham, A. and Jütte, R. (eds.), *Health Care and Poor Relief in Eighteenth- and Nineteenth-Century Northern Europe* (Ashgate), pp. 246–58.

London was also administered separately, whether in the form of the MBW, and later, from 1889, the London County Council, or the Metropolitan Asylums Board, established in 1867, which dealt with the poor law. The relative autonomy of Scotland and London was largely recognised as necessary, but not so the many other fault lines and muddled channels that defined the institutional landscape of health policy. Although the PLC and the GBH had been designed to provide clear national leadership, by the 1860s the sheer accretion of local responsibilities that had arisen under their watch led to mounting criticism, culminating in a sprawling royal commission inquiry in 1869–71, that the day-to-day administration of sanitary and poor law measures was hopelessly confused, including the relations between the two fields.

The result was the formation of the LGB, which combined the oversight of both. Yet this fared no better, despite four major internal reorganisations and the passage of the 1875 Public Health Act which consolidated earlier legislation. The division between sanitary and poor law functions remained, both centrally, within the LGB, and locally, resulting in another mammoth royal commission inquiry in 1905–9—which entertained arguments for the abolition of the poor law and a reconfigured central health department—while a host of other vital health-related functions were housed elsewhere. Chief among these were the factory inspectorate and the GRO, and later the school medical service and the national insurance commission. The formation of the Ministry of Health in 1919 incorporated the latter and reorganised a number of other oversight roles, but it fell short of the kind of integrated structure argued for by some. 'Joined-up government' proved elusive, despite the fact that calls for some kind of unified national bureaucracy had been made as early as the 1850s and were made consistently thereafter.

Variation

It is certainly true that some governments were more receptive to health policies than others, though it was not until the early 1900s, with the advent of New Liberalism and rise of the Labour Party, when health-related measures became the subject of sustained national party-political dispute. Throughout, however, there remained a broad commitment to working with, rather than against, the grain of local government and the interests of property and industry. This made for another problem: not inaction necessarily, but intense variation and lumpiness in the way that health policies were implemented.[46] MPs routinely mangled legislation that affected the rights of capital, for instance reducing the scope of factory legislation and inserting opt-out clauses in measures that sought to reduce industrial pollution.

More broadly, a general, if not complete, aversion to compelling local authorities to undertake particular measures left much to the discretion of elected councillors. Sometimes statutory compulsion came only after local authorities had paved the way, either through local bills or by taking advantage of enabling powers contained in permissive general statutes. Compulsory notification of infectious diseases was originally pioneered in the late 1870s by a handful of northern industrial towns using bespoke ('private') town improvement legislation; eventually, in 1899, parliament obliged all local authorities to adopt the measure, but by this point most had done so. The adoption of comprehensive water supply and water-borne sewerage systems was especially variable. While London forged ahead in the 1860s with its pioneering main drainage scheme, it was not until the 1890s when Manchester developed an intercepting system of comparable scope and design. Likewise, while some authorities opted to take public charge of their water supply at mid-century, chiefly in order to enhance the quality of supply, others left it in private hands until much later: whereas Manchester, Leeds, and Glasgow opted for municipal ownership in the early 1850s, London made the switch only in 1903.[47] To be sure, the GBH and then the LGB censured and scrutinised, encouraged, and inspected, but ultimately they could do little to prevent the development of a highly uneven culture of policy implementation.

46 Crook, *Governing Systems*.

47 Hassan, J.A. (1985), 'The Growth and Impact of the British Water Industry in the Nineteenth Century', *Economic History Review*, 38(4), pp.531–47.:

Resources

Capital expenditure on health-related infrastructure—e.g. isolation hospitals, poor law infirmaries, and water-supply and sewerage systems—increased enormously during the second half of the century, much of it secured through the Public Works Loan Board. Expenditure on staffing increased as well, in line with an expansion in the workforce dedicated to administering health measures. All of it, however, was constrained by a pervasive commitment to maximum economy, leading to another source of frustration: insufficient resources. This was especially so in relation to manpower, centrally and locally. Officials within the medical and engineering departments of the LGB complained not just of limited access to the ministers in charge—which was the privilege of the permanent secretaries—but of meagre staffing resources and low morale, and with some justification. During the late 1880s and 1890s, for instance, Treasury-imposed budgetary restrictions resulted in a small cut to the LGB's running costs, despite the fact that its workload rose by more than 50%.[48] The factory inspectorate was burdened with similar constraints. By 1900 it comprised one chief inspector, a medical inspector, five regional superintendents, forty-seven district inspectors, plus sixty or so assistants; but they were nominally responsible for over 200,000 registered factories and workshops.[49]

Officials employed by local authorities—MOHs, sanitary inspectors, borough surveyors and poor law medical officers—were exposed to the same pressures and complained of all manner of difficulties, chief among them unwieldly workloads, poor pay, short-term contracts and part-time status. In 1897 the Medical Officer of Health for Coventry lamented that just one inspector, an assistant and a clerk were responsible for some 12,000 houses situated on some forty miles of road. Most acute were the pressures faced by poor law medical officers. By design, 'outdoor relief' was dispensed only sparingly, but the provision of other services and facilities was also criticised as lacking, especially outside of London. By 1910, there were just fifteen poor law dispensaries in the provinces, compared to more than forty run by the Metropolitan Asylums Board.

Resistance

A final problem was resistance, which came in many forms, and at all stages of the policy process. The persistent pressure for economy noted above, which emanated from multiple sources—MPs, ministers, Treasury officials, councillors, among others—constituted a kind of resistance. Though calls for economy might mix with the broad endorsement of a particular policy, they could also inform more fundamental opposition, leading to paralysis and confusion. In the 1850s the GBH's sanitary agenda foundered in Birmingham on account of alarm among councillors and ratepayers at the costs of reforming the city's water supply and sewerage. It was not until the 1870s, with the arrival a new spirit of civic activism, that such matters were confronted with the necessary ambition. Different again, if just as pervasive, was the kind of petty obstructionism encountered at the local level, where councillors and trade associations meddled with the work of inspectors, poor law guardians interfered in individual cases of relief, and NIMBY-ish groups of property owners opposed the building of hospitals and sewage works.

More significant was organised public agitation calling for the repeal or amendment of particular policies. A cross-class coalition of evangelical Christians and radicals helped to bring an end to the coercive regime of the CDAs in 1886. A similar constituency vigorously opposed compulsory smallpox vaccination. Eventually formal exemptions were granted in 1898 on the grounds of 'conscientious objection', but opposition clearly took its toll on levels of compliance.

48 Macleod, R.M. (1968), *Treasury Control and Social Administration: A Study of Establishment Growth at the Local Government Board, 1871–1905* (G. Bell & Sons).

49 Cd. 688 (1901), *Annual Report of the Chief Inspector of Factories and Workshops for the Year 1900* (His Majesty's Stationery Office).

In hotspots of anti-vaccination sentiment, such as Gloucester and Leicester, the proportion of defaulting infants was over 75% in the late 1880s and early 1890s, and with predictable consequences.[50]

The entire field of popular access to doctors, medicines, and hospital care was similarly riven, with different groups seeking to amend or reject policies, or aspects of them, in their favour. Doctors jealously guarded their professional interests, friendly societies were fiercely protective of their autonomy, and charities carefully policed innovations in poor law policy. The making of the 1911 National Insurance Act is a case in point. Intensive lobbying by doctors, employers, friendly societies, and commercial insurers meant the act was more limited and complex than originally intended. Among other things, the promise of widow and orphan payments was dropped, while the need to expand the range of 'approved' providers so that it included commercial operators was accepted.

1.4 Policy lessons and concluding reflections

All of the above were articulate problems, in the sense that they were publicised and condemned at the time, and most of all by an expanding number of professionals, high and low, that constituted the frontline of health policy: MOHs, sanitary inspectors, borough engineers, poor law medical officers, doctors, and nurses. In terms of drawing lessons, it is tempting to take their side—as, to a certain extent, historians of the welfare state have—and to suggest that more success might have been achieved, more quickly, had there been more central consolidation, more resources, and more statutory compulsion, not to mention more compassion towards the very poor. There is some merit in this. There is no question, for instance, that more central coordination might have been achieved had the LGB not been subject to such severe financial constraints, which in turn damaged its reputation.[51] The examples might be multiplied. A different view is afforded, however, if we set these frustrations in the context not just of the long-term health improvements that were delivered, but of the broader policymaking environment in which they arose.

For one thing, the endemic, recurrent nature of these frustrations suggests they were more than just incidental: it suggests they were structural. The period 1848–1919 certainly witnessed the growing empowerment of professionals and experts, but it also witnessed the growing empowerment of MPs, localities and interest groups, as part of a lumpy process of what, crudely, we might call democratisation. The result was that health policy was deeply, and quite legitimately, a matter of politics, and of competing claims for resources and debates about local autonomy, personal liberty, and excess regulation, with all that this entailed in terms of the contested, frustrated realisation of policies. However, much health policy is matter of experts—and it became even more so during the Victorian period, with advances in epidemiology, bacteriology, chemistry, and engineering—it is also a matter of politics, in all its forms, from 'high' matters of principle to 'low' matters of taxpayer cost and inconvenience. Recognising this necessity and working through all of its implications and possible manifestations should be central to any culture of policymaking.

In retrospect, we can also see how at least one of the sources of frustration doubled as a source of long-term success: namely, the relative localism of health policy and the substantial, if far from total, autonomy granted to local authorities. While many bemoaned the resulting variations of implementation, it also afforded considerable room for policy experimentation, allowing for new possibilities to be explored and new standards established. As noted above,

50 (1896), *Final Report of the Royal Commission Appointed to Inquire into the Subject of Vaccination*, C. 8270 (Her Majesty's Stationery Office).

51 One reason why the new functions which evolved in the Edwardian period—e.g. the school medical service and National Insurance—were housed elsewhere and not administered by the LGB was on account of its reputation for bureaucratic overload and sluggishness. In other words, one consequence of these restraints was further administrative fragmentation.

notification of infectious diseases was pioneered locally much before it was made compulsory on a national scale, prompting useful reflection about quite how it should work in practice; but the examples are many. During the 1890s the school boards of London and Bradford set new standards relating to the medical care afforded to elementary pupils, presaging the national legislation that followed after 1905. The best instance is the monumental task of remaking the hydraulic infrastructure of Britain's towns and cities. Even after the MBW had demonstrated how a combined, water-borne sewerage system might be built on a vast scale, multiple other elements still required refinement: sewer ventilation mechanisms, the precise design of water-closets, and above all ways of dealing with the novel substance of sewage. It took until roughly 1900 for all the technically intricate parts to function and cohere in a way that was ecologically sound and reliable. This would have taken much longer had local authorities not enjoyed the freedom they did. This, too, offers another useful lesson: central and local authorities should see policymaking as a shared endeavour, with each as open as possible to the insights and innovations of the other.

Finally, we should be clear about how and why long-term health improvements arose as a result of the policy interventions briefly surveyed above. Clearly, these improvements were a cumulative and diffuse achievement: a matter of accretion and working on multiple fronts. Part of the answer, as historians have long argued, is that policymakers, and the public to whom they were ultimately accountable, gradually accepted the need for greater 'intervention'. Yet, in foregrounding this ideological layer of change, historians have unduly neglected the very material, practical and day-to-day layers of what took place: which is to say, the building of durable technological and administrative systems that changed the habits and expectations of the public. While governments came and went and the political composition of local authorities changed, it was these systems which, however gradually, amid all sorts of frustrations—see above—established themselves as a permanent presence in people's lives: better, cleaner water-supply systems; more expansive, functional systems of sewerage; systems of inspection; systems of building regulation; systems of stamping out infectious diseases, among many others. It is not just that they slowly changed people's habits or awareness of the protections they might enjoy. They also furnished the environment in which scientific breakthroughs could be practically applied, chief among them those of bacteriology as it emerged as a recognisable science from the 1880s (as in the analysis of water and the treatment of sewage; the use of the diphtheria antitoxin in local notification-isolation systems; and the emergence of tuberculosis (TB) as preventable, notifiable disease). The lesson here is not simply the commonplace one that policymaking should take a long-term view of the changes it seeks to effect. It is also that it needs to reckon with the multi-layered, cumulative and systemic nature of how policies work in practice and engage fully with both the challenges and the possibilities that this presents.

Chapter 2: British health policy, 1919-1948

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Key messages

The central state's role in health policy grew in the interwar period, in developing national health insurance, in steering and financing local government services, and ultimately in the creation of the NHS.

This reflected growing dissatisfaction with the liberal approach outlined in Chapter One, which favoured pluralism and localism in provision and cast health security as individual responsibility.

In addition to the extension of the franchise, the rise of Labour and the contingent impact of war, this change arose from concerns about spatial and social inequities, inefficiencies, and poor coordination of health services.

2.1 Introduction: from pluralism to statism

The period 1919 to 1948 had three major policy phases. The immediate post-war years saw the establishment of the Ministry of Health, and the full implementation of national health insurance. In 1929 came the Local Government Acts, which reshaped the financing and delivery of public health at a local level, and signalled a substantive break with the Poor Law as provider of medical care. Then, following the Second World War, the National Health Service (NHS) was created. There were three separate Acts, for England and Wales (1946), Scotland (1947), and Northern Ireland (1948), and the service was launched on the 'appointed day' of 5th July 1948.[52]

The coming of the NHS is rightly regarded as a 'big-bang' reform, in that it radically broke with past administrative and financial structures. The developments outlined above had left Britain in 1919 with a highly pluralistic model. The private, for-profit sector was largely confined to general practice, small numbers of 'nursing homes', and private beds in many voluntary hospitals. The charitable, non-profit sector dominated acute hospital care, with an extensive network of teaching, general, special, and 'cottage' hospitals, while voluntary associations piloted forms of community health. Public health was the remit of local government, with rural, district, and county borough councils (and the local county councils) delivering environmental and clinical care, and county councils providing psychiatric asylums. The separately financed Poor Law delivered a mix of medical and social care in institutions for poorer citizens, where the Victorian stigma of 'less eligibility' lingered. Finally, the central state had entered the field with social health insurance, using friendly societies as third sector agencies to deliver a nationally uniform policy of sickness coverage for the working class.

[52] Space constraints mean that where policy and legislation differed across the four nations, this survey concentrates on England and Wales.

The NHS replaced this diversity with unity. It was: universal, extending coverage to all citizens regardless of income; comprehensive, providing the full range of clinical services 'from cradle to grave'; and free at the point of use, funded principally by general taxation. Ultimate authority lay with the Minister of Health in parliament. The hospitals were 'nationalised', with local authority and voluntary institutions coming under public ownership with new administrative structures of Regional Hospital Boards and, for the teaching hospital groups (excluding Scotland), separate Boards of Governors. Hospital consultants became salaried employees, and while private practice was permitted it was assumed this would be minimal. General practitioners (GPs) retained their status as private contractors, with the vast majority joining the service and coming under regional executive councils. The empires of local authority Medical Officers of Health (MOHs) were reduced to more minimal community and public health duties, with clinical services removed and primary care now accessible to all through GPs.[53]

Given the depth of these changes it is tempting to read interwar policy developments retrospectively as stepping stones to reform. This should be resisted. Despite precursors, the internal policy process did not begin until 1941, and the final shape of the NHS did not emerge until Aneurin Bevan became Minister of Health following Labour's victory in 1945. This chapter will therefore follow the format of its predecessor, outlining the different strands of health policy, then discussing ongoing frustrations, before addressing the different explanations advanced by historians for the coming of the NHS. First though, how had the broader context of health policy changed by the interwar years?

2.2 Contexts: economy, demography, politics

Interwar Britain was one of the world's advanced industrial nations, with ample wealth to devote to social welfare, founded on finance, manufacturing, and services. It still commanded a global empire though now its economic dominance was challenged by Germany and the United States. Its early advantage in coal, iron and steel, textiles, and ship-building was diminished by growing competition that left it exposed to downturns in world trade, notably the post-war slump of 1920-21, then the Depression of the 1930s. Those parts of Britain which relied primarily on heavy industry, like the North East and South Wales, were especially vulnerable to unemployment and its health consequences.

Overall, the long-run improvement in population health continued, with British life expectation at birth rising from 57 years in 1919 to 69 in 1948, and infant mortality declining from 96 per 1,000 live births to 40. There had been some 220,000 excess deaths during the influenza pandemic of 1918-19, but their social impact was obscured by the tally of war dead. Maternal mortality remained high, due partly to incompetent obstetric care, and would only be overcome by antibiotics. Underlying the overall trend was an epidemiologic transition in which infectious disease risk diminished. The reasons for this were manifold: economic development (improvements in housing, diet, clothing, hygiene products); public health interventions (sanitation, water, vaccination); female education and empowerment (smaller families, domestic hygiene); and medicine (smallpox vaccine, diphtheria serum, germ theory, Listerian surgery, antimicrobials).[54] Longer lives though, were not necessarily healthier. Instead, the prevalence of sickness rose as populations aged, due to the increased duration of illness in the over-60s, with circulatory diseases, colds and flu, and musculoskeletal ailments the prime causes. Paradoxically then, the mortality transition raised demand for medical care.

53 Webster, C. (1988), *The Health Services since the War, Vol. 1, Problems of Health Care: The National Health Service before 1957* (Her Majesty's Stationery Office).

54 'Listerian surgery' refers to use during and after surgery of methods to prevent infections in wounds using antiseptics to destroy germs. The method was developed by British surgeon Joseph Lister, who was the first to apply the science of germ theory to surgery. His 'Antisepsis System' formed the basis of modern infection control. See, for example, Science Museum (2018), 'Joseph Lister's Antisepsis System' [accessed 29/10/2023].

Politically, Britain achieved universal adult suffrage only in 1928 with the enfranchisement of women over the age of twenty-one. From 1922 national party politics were a Labour and Conservative duopoly and, notwithstanding the significant presence of working-class Tories, divided principally on class lines electorally, with Labour the party of the workers. In local government socialist councillors exerted sustained influence on health policy, though nationally Labour's terms in power were too brief for distinctive impact. However, it gained a large majority in 1945, thanks to the political promise of the welfare state. This victory would open the door to the creation of the NHS.

2.3 The strands of health policy

In identifying the strands of health policy in this period, we can consider the Ministry of Health, local government, Poor Law, and the voluntary hospitals. Though nominally independent, the latter were also an object of 'policy', planners deeming them components of the larger system. The categories outlined in Chapter 1 can helpfully be reused, with some modification, to survey this next phase. The keynote, once again, is the plurality of areas constituting 'health' policy.

Environment and public health

Historians of interwar welfare have largely regarded environmental health as 'done' by 1919, in that urban infrastructures of sewerage, drainage, and fresh water and their accompanying legal and fiscal frameworks were largely in place. However, environmental expenditure consumed the largest proportion of local government public health outgoings, sanitary inspectors formed a substantial workforce, and extending systems into rural areas was ongoing.[55] The challenge of inorganic waste disposal accelerated alongside consumerism, to be addressed through landfill and incineration. A related concern was air quality, with expanding attempts to measure and record pollution from particulate matter, notably in industrial regions.

Housing became an area of growing activity, thanks to legislation for slum clearance and building subsidies (1919, 1923, 1924, 1930, and 1935), though this was not exclusively a health policy. As the post-war 'Homes Fit for Heroes' slogan hints, democratic politics, social solidarity, and visions of modernity were also drivers. Nonetheless, MOHs were actors in the municipal decision-making processes behind development. The correlation between infectious disease mortality and overcrowding was now understood, as was the relationship between diarrheal diseases and poor sanitation. In Glasgow for example, the housing programme was explicitly linked to Tuberculosis (TB) policy, and duly reduced deaths.

Finally, the rise of motorised transport led to new environmental controls such as traffic lights, speed regulation, road markings, and the Highway Code. Again, this was not primarily a health policy area, but the remit of highways and engineering departments. Car crashes were conceptualised as 'accidents', a trope denoting individual misfortune rather than probabilistic outcomes of collective behaviour. Their victims fell mostly on Accident and Emergency (A&E) and orthopaedic departments of voluntary hospitals, bringing more middle-class patients through their doors. They were not yet deemed matters of public health policy, and it was the voluntarist Royal Society for the Prevention of Accidents (formed 1916) which led the debate.

Mothers and children

Another significant category of local government public health expenditure and staffing was 'maternal and child welfare' (MCW). For mothers it included: a salaried midwife service from 1936; more maternity beds in municipal hospitals; community visiting; ante-natal and post-natal classes; provision of food and milk supplements. For children it meant: free school meals; the School Medical Service; and clinics and hospitals addressing the child health problems which were exposed by school inspections.

[55] Here and passim: Harris, *The Origins of the British Welfare State;* Welshman, J. (2000), *Municipal Medicine: Public Health in Twentieth-Century Britain* (Peter Lang).

Much of this originated in Edwardian Britain, with its intrusive, maternalist philanthropy and its fears that 'physical deterioration' would undermine imperial might and industrial productivity. By the interwar period, the structures were in place and their channels used to improve outcomes. Declining infant and child mortality owed something to these new structures, and their benefits also sustained women's and children's health during the war and the 'hungry thirties'. The female vote was probably a spur to political action, and there is evidence that Labour councils prioritised MCW. Overall, there was per capita expansion in health expenditure, though it is hard to fully quantity, as school medicine spending was submerged within the overall education budget.[56]

Communicable and non-communicable diseases

The epidemiologic transition evinced in cause of death statistics testifies to the impact of the 'stamping out' policies described above. Like those for MCW, previously established institutions maintained their momentum, even if by the 1940s, discussions began on closing infectious disease hospitals as usage declined. These isolation hospitals for illnesses like smallpox, scarlet fever, diphtheria, and the salmonellas were one strand of the control policy. Notification of infectious diseases continued to be used to track outbreaks, and trends were reported in annual MOHs reports for boroughs and counties. Smallpox vaccination and surveillance continued, with the last outbreak of variola minor occurring in 1923. Despite the availability of diphtheria and BCG vaccines by the 1930s, British policymakers were comparatively slow to adopt these, mindful of earlier anti-vaccination controversies. Tuberculosis continued to be managed with sanitorium treatment revolving around bedrest, exercise, fresh air, and diet, although neither this, nor therapies such as injected sanocrysin or artificial pneumothorax, were definitively proven to be effective.[57] Social support via TB outpatient clinics and workshops for recovering patients were additional strategies. Finally, sexually transmitted infections came under the remit of public health from 1916, after scares about the health of soldiers (not sex workers) overturned the existing taboos. The approaches were either to treat in municipal clinics or contract voluntary hospital services.

Non-communicable disease epidemiology was not yet established, and cancer and circulatory diseases were not considered part of the local MOHs' policy remit. Cancer treatment through radiotherapy was a matter for the voluntary hospitals, though discussions of planning to ensure fair access were beginning. Again, it was third sector organisations, the Imperial Cancer Research Fund (founded 1902), and the Cancer Research Campaign (1923) that took the initiative. Nor were diseases related to substance use yet medicalised. The tobacco/lung cancer link was not understood, despite early findings and control policies enacted in Nazi Germany during the 1930s. Meanwhile, the control of drugs and alcohol began with concerns about public disorder, not health.

The major area of non-communicable disease which did fall under local government was psychiatric illness. Expenditure and institutional responses came under two categories, the mental hospital for those who might recover, and institutions for 'mental deficiency', now termed learning disability. Policy to the latter focused on defining those who fell within its parameters and so merited intervention. The Mental Deficiency Act of 1913 had established a sub-category of 'moral defectives' which included women with illegitimate children on poor

56 Here and passim: Gorsky, M. (2011), 'Local Government Health Services in Interwar England: Problems of Quantification and Interpretation', *Bulletin of the History of Medicine,* 85, pp. 384–412; Gorsky, M. (2008), 'Public Health in Interwar England and Wales: Did It Fail?', Dynamis, 28, pp. 175–198.

57 Sanocrysin is an inorganic compound, an injectable salt with a gold content of 37%. It was first used in Denmark in the 1920s. See, for example, (1925), 'Sanocrysin – a gold standard for tuberculosis', Am J Public Health (NY), 15(2), pp. 144-145. Artificial pneumothorax (APT), refers to the practice of inserting air or gas into the cavity between the lungs and chest wall, causing the lung to collapse (i.e. inducing pneumothorax), in an attempt to close tuberculosis cavities. This developed following observations that tuberculosis patients who developed spontaneous pneumothorax showed signs of improvement. See, for example, Rakovic, G (2010), 'Artificial Pneumothorax: Tapping Into a Small Bit of History', *Canadian Medical Association Journal*, 182(2), p. 179.

relief, while that of 1927 broadened it to include incapacity from illness or accident. Eugenic thought influenced the report of the Departmental Committee on Sterilisation, known as the 'Brock Report', to the Ministry of Health in 1934 which recommended legalising voluntary sterilisation in cases of 'mental disorder and deficiency'.[58] Politicians, however, rejected this expert consensus. Otherwise, legislation reflected gradually enlightening attitudes. The Mental Treatment Act (1930) replaced the terms 'lunatic' and 'asylum' with 'patient' and 'hospital', allowed for voluntary admission and discharge, and empowered local authorities to fund out-patient and aftercare facilities.[59]

This period was that of peak psychiatric institutionalisation in Britain, with in-patient numbers rising from roughly 110,000 to 150,000. The reasons are complex. From the start of asylum building, demand for admissions had followed supply of beds, as families embraced this option of care for sick relatives hitherto managed at home. Also, population aging meant greater numbers of incurable, institutionalised older patients, many with senile dementia. Such patients were also housed in Poor Law workhouses, where their needs fell across the medical/social care border, which manifested materially in the house/infirmary division of the building. Mental hospitals combined carceral elements, restraining patients' access to the outside, with 'asylum' aspects like work routines in semi-rural settings. Pharmaceutical cures were limited, though barbiturates were used. There was experimentation with insulin and cortisol injection, while physical treatments included electro-shock therapy, lobotomy, and leucotomy.[60] The availability from the 1950s of chlorpromazine, a medicine used to treat schizophrenia, bipolar disorder, and acute psychosis, finally opened up the policy option of deinstitutionalisation.

Finally, this was the precursor period for British geriatric medicine, thanks to the pioneering doctor Marjory Warren. Working with older 'chronic' patients transferred from the Poor Law to her municipal hospital, she initiated clinical approaches to those patients hitherto deemed incurable and meriting only minimal social care. These approaches included classificatory systems, physical adaptation of the environment, and ancillary care from physical and occupational therapists, podiatrists and others. Forcefully publicising these methods, she influenced more widespread speciality in geriatric medicine in the mid-1940s.[61]

Health and the 'welfare state'

Although the term 'welfare state' was not current until the post-1945 era, there is a good case for seeing the health insurance legislation in 1911 as the inception of the British welfare state. Launched in 1913, the scheme was disrupted by the First World War, but then quickly became established. By the late 1930s, 63% of adult men and 30% of women were covered. These were working-age adults under the earnings limit. Their national insurance stamp entitled them to a sickness benefit when ill and access to a GP, though not to hospital, so that the existing mix of local government and charitable funding would remain undisturbed. Initially a tuberculosis benefit was included, though this was replaced in 1921 when the duty to provide sanatoria and aftercare was delegated to local authorities, supported by a central grant. Otherwise, the arrangements continued those established by the friendly societies, with payment for panel doctors calculated on a capitation basis (i.e. per head of patients on their list), rather than by 'fee for service', as was more common in Europe. The latter reimbursement model proved more inflationary as it incentivised more costly treatments. Conversely payment by capitation probably encouraged British doctors to undertreat. It also provided a precursor to the 'free at the point of use' model that would carry forward into the NHS.

58 Board of Control, Committee on Sterilisation (1934), *Report of the Departmental Committee on Sterilisation*, His Majesty's Stationery Office.

59 See, for example, Hilton, C. (2020), '90 years ago: the Mental Treatment Act 1930 by Dr Claire Hilton', *Royal College of Psychiatrists* [accessed 20/10/2023].

60 Leucotomy (sometimes spelled 'leukotomy', also called lobotomy), is the surgical severing of white nerve fibres in the brain's frontal lobes. See, for example, Britannica (updated 2023), 'Lobotomy' [accessed 29/10/2023].

61 Thane, P. (2000), *Old Age in English Society* (Oxford University Press), pp. 436-8 and passim.

At the local government level there were four funding streams. First the poor rates, which in Scotland were administered by the parishes and in England and Wales by Boards of Guardians within larger 'Unions' of parishes. With respect to health, these funded domiciliary medical relief, the workhouses, of which an increasing number now had separate infirmaries, and transfer payments to, for example, county asylums that accommodated Union patients. Next were the 'rates', whose level varied with the rateable value of property in each local authority, and which funded public health department activities. Third, some councils levied user fees, in areas such as MCW and sexual health. Finally, local authorities were supplemented by steady growth in funding from the central state. This was initially provided as percentage grants, which matched locally raised tax funding at a proportionate level to encourage specific services. They met (roughly) between half to two-thirds of the costs of MCW, TB, sexual health, and 'mental deficiency'. Exchequer funds also underpinned local health through the education grant, some of which sustained schools' health programmes.

Major change to this structure came with the 1929 Local Government Act whose aim was to 'break up' the Poor Law. The separate unions were dissolved and their duties taken over by local authorities under their 'Public Assistance' committees, the rebranding denoting the aim of reducing stigma. This allowed, though did not oblige, councils to 'appropriate' workhouse infirmaries and develop them as modernised municipal hospitals accessible to all citizens. This Local Government Act also replaced central percentage grants with a block grant assessed using a population-based formula, after worries the former were unfavourable to poor areas with low rateable values.

As for the voluntary hospitals, the Ministry of Health appointed the Cave Commission in 1921 to assess the need for state funding. They were then still predominantly financed by philanthropy, but war and pandemic had created a backlog of building work, sapped staffing, and undermined giving. The Cave Commission debated whether tax or national insurance might rescue the situation, but voluntary hospital interests argued the crisis was temporary, and so it transpired. However, although charitable income continued to grow it was insufficient to meet the pace of demand, compounded by popular faith in biomedicine, growing middle-class hospital usage, the aging population, and increasing referrals from GPs seen under national health insurance. The shortfall was taken up by full-cost private beds, by charging means-tested user fees, and by the proliferation of working-class hospital contributory schemes. The latter were not strictly insurance but effectively conferred a right of admission to subscribers, who were excused the means test. The scheme would then pay the hospital, though not at full cost.

2.4 The frustration of health policy

Against a backdrop of improving population health then, it is tempting to admire the breadth of provision which Britain's pluralist system delivered. The combination of civil society initiatives, working-class mutualism, the delegation of powers to local government, national health insurance, and the modernised Poor Law seemed to provide a viable, diverse system. However, the areas of frustration experienced by citizens and officials outlined in Chapter One were still present, and were magnified as expectations grew.

Variation

Initially policymakers assumed the virtue of diversity rested in the capacity of local knowledge to shape services. Responsiveness to peoples' wishes would best occur through grassroots representative mechanisms of Poor Law Guardians and local councils. There is limited evidence that this did indeed happen in the boroughs, where Labour councils spent more on TB and MCW. However, as historians charting the rise of central government social expenditure have argued, once public opinion shifted decisively in favour of an equitable level of service, spatial variation became politically less attractive. national health insurance and the post-1929 block grant exemplify this changing reality, as government adjusted to a fully democratic polity.

From this point on, persistent problems of variation in provision became more noticeable. The voluntary hospitals were unevenly distributed across the country, since the propensity for charitable giving was greater in wealthier areas. Large urban centres were generally well served, and there were generous ratios of beds and doctors to population in county towns and seaside settings. Less well-attended were rural areas and smaller industrial towns, which were also unattractive to GPs seeking to blend private earnings with national health insurance income. Access to specialty care – hospitals for the eye, ear nose and throat, cancer, children, gastro-enterology, and so on – was also maldistributed. The 'inverse care law'[62] had not yet been articulated, but the observation that services were sparser where need was greater began to be expressed. To some extent the hospital contributory schemes offset this, for their money would 'follow the patient'. However, the schemes' localism created new variations in subscription and remuneration rates, collection methods, and benefits. These raised difficulties when a patient contributing to one hospital scheme approached, or was referred to, a different voluntary or municipal hospital.[63]

Finally, social variations in coverage became more apparent. As national health insurance bedded in, its basis in waged employment excluded categories such as dependants (mostly wives and children) and older people. The deficient healthcare available for poorer women and pensioners with access only to deficient facilities of the Poor Law (renamed in 1929 'Public Assistance') was particularly problematic.[64] Middle-class families whose earnings were just above the income limit were also disadvantaged, obliged to ration care-seeking in ways national health insurance patients were not. With respect to municipal services, the differences in rateable capacity were another source of socio-spatial divergence in provision, though in the 1930s the central block grant system began to moderate these. Fortuitously the Treasury's forward estimates were made just before a period of falling prices left recipient councils somewhat better off. The success of state underwriting raised the question of how sustainable localised funding was in the future.

Coordination

Interwar policy documents relating to health services are replete with terms like 'integration', 'cooperation', and 'coordination'. In part this was a language imported from business management in the era of vertical integration of firms and research and development for strategic planning. Yet it also reflected concern about problems of variation in an era of rising expectations. A further issue was duplication, which became more salient as hospital specialties like radiotherapy and orthopaedics advanced. If the voluntary and municipal hospitals worked in isolation, there was no mechanism for optimising regional provision across the two sectors.

The Ministry of Health's Dawson Report of 1919 advanced an early vision of co-ordination. In its nationwide regionalisation plan, central cities would house teaching and special hospitals formally linked by referral channels to general hospitals in the smaller cities, and beyond them to a network of health centres in which primary and community care would be delivered. Born of post-war statist optimism, this blueprint was soon shelved as the voluntary hospitals recovered. It would re-emerge though in different ways.

The voluntary hospitals watched warily the parallel growth of public hospitals and the emergence of 'coordination' critiques. Their representative body the British Hospitals Association commissioned Lord Sankey to investigate, and his report (1937) recommended a greater degree of cross-hospital working to address common interests like waiting lists.

62 Tudor Hart, J. (1971), 'The Inverse Care Law', *The Lancet*, 297(7696), pp. 405–12.

63 For references see Gorsky, M. (2015), 'Voluntarism' in English health and welfare: visions of history', in Lucey, D.S. and Crossman, V. (eds.), *Healthcare in Ireland and Britain from 1850: Voluntary, Regional and Comparative Perspectives* (Institute of Historical Research), pp., 31–60, at pp. 49-52.

64 Spring Rice, M. (1939), *Working Class Wives: their Health and Condition* (Penguin).

Meanwhile, concerned policy networks began to form at local levels, drawing together MOHs, hospital philanthropists, contributory scheme leaders and representatives of university medical schools, the latter seeking improved access for teaching and research. In some conurbations, like Manchester, Sheffield, and Merseyside these networks consolidated into 'hospitals councils', providing a forum for rationalising diversity through, for example, arranging regional portability of contributory schemes.

More formally, Section 13 of the Local Government Act empowered councils to establish consultative committees with voluntary hospital representatives for planning and co-ordination. Evidence for their success was mixed. Ministry reports suggest they were created in many, but not all, places. They did not always work well, as for example in London, where friction between elite philanthropists and local county council socialists was reported. Analysis of the national distribution of municipal hospital general and maternity beds suggests that by the late 1930s the public sector was plugging gaps in voluntary provision, but whether this owed much to policy is unclear.

Resources

There are four key areas of debate about resource sufficiency and the central state. The first concerns the health effects of the Depression. Some scholars suggest the state failed in its duty to protect the health of poorer citizens during the 'hungry thirties', citing the localised efforts by MOHs to raise the alarm about nutrition-related diseases. Others argue, based on mortality statistics, that regional disadvantage in the period was not noticeably worse than at other times, and if anything, slightly better thanks to the nascent welfare state. Consensus inclines now to the latter reading, though the point about persistent under-resourcing stands regardless. Secondly, early historians of the NHS argued that the voluntary hospitals faced a funding crisis in the 1930s, due partly to the Depression and partly the failure of charitable giving. Thus, they were rescued when the wartime Emergency Hospital Service arrived in 1938, bringing with it state funding, and preparing the ground for the NHS. Subsequent work has nuanced this reading. Some voluntary hospitals, particularly in London, were indeed drastically running down capital reserves for building and current expenditure. Others though remained in a strong position, so we cannot view the creation of the NHS as a straightforward response to generalised financial crisis.

A third area is the relative under-resourcing of the Poor Law/Public Assistance side of local public health. We know that overall there was a real, long-term rise in local government public health expenditure in the period, and that, for example, the municipal general hospitals enjoyed investment and upgrading. This reflected the thrust of LGA policy and the help that central funding directed towards MCW, schoolchildren and services for adults of working age. No such support or policy attention was directed to the older, poorer residents of workhouses/public assistance institutions, which continued to be locally resourced. Case studies of finance suggest a lack of real growth, and survey evidence from the 1940s details inadequate infrastructure and staffing. Here was one antecedent of the asymmetries of the health/social care border that would continue into the post-war era.[65]

A final issue concerns the class basis of national health insurance and the downsides of the 'capitation system' of doctors' remuneration.[66] Evidence suggests that panel doctors were incentivised to treat their national health insurance patients less well than private ones, with records showing that, for example, consultation times were shorter for the former.

65 Bridgen, P. and Lewis, J. (1999), *Elderly People and the Boundary Between Health and Social Care 1946–91: whose responsibility?*, Research report (Nuffield Trust).

66 Capitation refers to paying a provider or group of providers to cover the majority (or all) of the care provided to a specfici population across different care settings. The regular payments are calculated as a lump sum per patient. Definition taken from Monitor and NHS England (2015), 'Guidance. Capitation: an introduction', *National Health Service*.

2.5 A policy 'Big-Bang': accounting for the NHS

By the later 1930s then, various pressure points had emerged for policymakers, to which a coordinated system seemed the panacea. There were also trends within public financing of using central subventions to advance national goals. A broad-based acceptance had emerged of collective payment arrangements, whether local taxation, national health insurance or contributory schemes, whose benefits were widely appreciated. In both voluntary and public sectors, a sense of entitlement on the part of ordinary users was replacing the charitable gift and stigmatised poor relief. All these were tendencies that opened policy space for proposing a more comprehensive and universal service.

We have also observed the emergence of different actors interested in this agenda. First were officials at the Ministry of Health, who had sought to steer pluralism towards an integrated system. Second were labour movement figures, though they did not speak with one voice: the TUC favoured universalism through extension of national insurance; Fabians and Socialist Medical Association members envisaged a full local government health service, tax-funded and democratic; meanwhile contributory scheme leaders who valued community hospital governance accepted the status quo. The medical profession was also split between conservatives and more progressive elements. Voluntary hospital leaders were likewise divided, with some countenancing greater integration. County and borough councillors naturally wished to retain and extend their accrued health powers. Finally, there were the regional policy networks of medical academics, philanthropists, and public health officials who were already engaged in rationalising and system building.

Given these conducive circumstances then, how have historians explained the passage of the NHS Acts?[67]

Transnationalism

Policy did not develop within a national silo, for welfare expertise transcended borders, offering practical ideas and new horizons of possibilities. The Soviet Union's 'red medicine' exemplified state-led universalism, while Weimar Germany with its expansive health insurance system had provided a constitutional right to health. New Zealand from 1938 provided a model tax-funded universal national health service, albeit the obduracy of the doctors' union had forced the retention of modest user fees. Finally, international bodies like the League of Nations Health Organisation and International Labour Organisation disseminated information for policy learning.

'Voluntary failure'

Introducing the NHS Bill to Parliament, Bevan alluded to spatial inequity, the result of the 'caprice of charity', indignities of philanthropy's class hierarchies, and the inefficiency of poorly resourced cottage hospitals, where one might 'expire in a gush of warm sympathy'.[68] The failings of the voluntary hospitals cannot directly explain the arrival of the NHS, but they did inform a sense that greater fairness and effectiveness could be achieved under state control.

Impact of war

The major short-term catalyst was war and the incursion of government into the hospital sector. As home front mobilisation began in 1938, an Emergency Medical Service brought the hospitals under unprecedented state direction in preparation for military and air-raid casualties. Public funding flowed to voluntary hospitals providing salaries for hitherto honorary consultants,

67 Webster, *Health Services;* Honigsbaum, F. (1989), *Health, Happiness and Security: The Creation of the National Health Service* (Routledge).

68 Bevan, A. (1946), *House of Commons Debates. National Health Service Bill, Volume 422: debated on Tuesday 30 April 1946* (Hansard), cols. 46-74.

while enforced planning of bed and patient distributions swiftly accomplished the rationalised distribution which earlier officials had sought. Doctors allocated posts in municipal and public assistance institutions learnt more of the neglect of older, long-stay patients, further catalysing the development of geriatric medicine inspired by Marjory Warren.

War also reshaped political expectations, after the *Beveridge Report* provided a blueprint for a universal welfare state to slay the 'five giants' of want, ignorance, squalor, idleness, and disease. Beveridge's briefly sketched ideas for a comprehensive, universal health service, integral to post-war social security, became engrained in public opinion.

Pressure politics

In 1941, Health Minister Ernest Brown told Parliament that policy development would begin, and a White Paper was commissioned. Different models were discussed, and the various actors sought to advance their positions, though the Conservative Minister of Health in the National government, Henry Willink, found that all mooted solutions generated opposition. Ministry bureaucrats and municipal Labourites pushed for a local government administrative structure, financed by different combinations of national or local taxation, charity or insurance. This interest also envisaged greater regulation of general practice to promote better distribution and ensure service free at the point of use. Local government associations sought to consolidate their power and importance. The British Medical Association (BMA) refused the authority of local councillors and salaried service, aiming to maximise autonomy and remuneration. Voluntary hospital leaders also defended their independence, though most agreed the contributory schemes were unsuitable as funders. Stalemate ensued by 1945.

Institutionalism

Electoral victory finally empowered Labour to resolve the impasse. Institutional factors now came into play. Westminster's 'first past the post' system tended towards two-party politics, in which a working majority empowered the winner to carry radical reform. The tradition of cabinet government and a strong party whip tended to suppress internal objections. Also, a streamlined committee system for scrutinising bills and the absence of the second chamber's power to reject legislation both removed veto points at which opponents might have halted legislation (as happened in Europe and the USA). However, Labour still had to determine policy.

The role of Labour: ideology and compromise

Though a socialist and trade-unionist, Bevan was also a pragmatist willing to compromise with the doctors, ultimately the only interest group with real leverage. The resulting settlement met the major social democratic goals of universalism, comprehensiveness, and services free at the point of use, with redistributive financing reliant principally on progressive income tax. The objections of voluntary hospital, contributory scheme, and local government leaders were overruled, so that almost all hospitals joined a national network. Voluntary finance subsequently played no part, other than marginal support for non-core services, like research and amenities. The BMA was then divided. Hospital consultants were mollified with handsome salaries – 'I stuffed their mouths with gold' Bevan reputedly said – and, now isolated, the GPs' bluff was called and most joined the service.

Bevan compromised however, in allowing the continuation of private practice as a sweetener to the doctors. He further enraged socialist opinion by reducing local government to limited public health duties, inscribing a border between health (the NHS) and social care (local government). Rows over 'bed-blocking' and cost-shunting would soon follow as numbers of older, frail individuals with complex care needs grew. Another long-running sore was the NHS's 'democratic deficit', for Bevan surrendered administrative power to board appointees from existing regional elites, minus the erstwhile working-class contributory scheme members. For all that though, Bevan had achieved the goal that eluded earlier ministers, and the NHS was launched.

2.6 Concluding remarks

This chapter has detailed the breaking of the liberal consensus outlined in Chapter One. The incipient welfare state reconfigured risk from a matter of individual responsibility to one of actuarial calculation - the 'magic of averages' in Churchill's phrase; it was also universal (initially within an income limit), no longer treating coverage as personal choice; and it was redistributive. The localist and pluralist health system prior to 1918 attracted rising dissatisfaction and by the 1930s there was a desire for reform to further, in today's political language, the goals of equity and efficiency.

We cannot know whether the NHS would have emerged without contingent causal factors, like the wartime emergency or Bevan's individual agency, but we can understand it as more than the creation of Whitehall technocrats. Instead, it reflected a culture of redistribution deeply engrained in national life, through working-class mutualism and middle-class charity which had long ensured access to healthcare regardless of wealth, and through local democracy, which made health rights an aspect of citizenship.

Is this a lesson of history for today's policy makers? Not exactly, for circumstances and political culture change, though it should, surely, be part of institutional memory. What we can say though, is that these were the factors which brought the NHS into being, with all the virtues that explain its place in the public's affections, and the vices that Bevan's settlement left unresolved. In addition to the controversies surrounding private medicine, the health/social care divide, and democratic control, his empowerment of the central state to set spending limits has repeatedly left the NHS vulnerable. In contrast to countries reliant on social insurance operated through third parties, the NHS model has remained prone to 'institutionalising parsimony'.[69] This has occurred when governments prioritising economic production and consumption have under-resourced the service, disadvantaging its users. Such policy choices would characterise the long periods of Conservative hegemony, in the 1950s, the 1980s and, of course, the 2010s.

[69] Klein, R. (1983), *The New Politics of the NHS: From Creation to Reinvention* (Radcliffe Publishing), p. 253.

Chapter 3: British health policy, 1948-1974

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Key messages

After its foundation in 1948, the NHS attracted the lion's share of attention and resources in health policy, which was primarily driven by the Ministry of Health (though with some influence exerted by local government and regional NHS authorities).

Grounding the new health service and modernising it for the future formed the primary goal among policymakers.

Nonetheless, for all the blurring of lines between 'health policy' and the NHS's curative services during the post-war decades, important changes also took place in public health, particularly in response to increases in the instance of chronic disease associated with longer life expectancy.

In addition, novel forms of policy expertise and policy actors, such as health economics and management consultants, emerged and took on a high degree of authority.

The first wholescale administrative restructuring of the NHS did not arrive until 1973/74, underlining that this type of reform did not absorb health policy with such frequency until later in the institution's history.

3.1 Introduction

The main figures driving health policy between the years 1948 to 1974 sat within the Ministry of Health, with local government and regional NHS authorities also exerting some influence. The new nationalised medical system – and particularly the development of its curative services – regularly absorbed the lion's share of both internal discussion of 'health policy' and how the public understood this arena of government activity. This focus followed from the government's unprecedented involvement in the funding and delivery of health services after 1948. Indeed, this attention dovetailed with a broader interest in organising health services by governments around the world, such as the successful establishment of compulsory health insurance in Sweden in 1955 and the less successful attempt by President Harry Truman to introduce a national health insurance programme in the USA during the late 1940s and early 1950s.
In Britain, with the NHS legislation in place, the goal for many politicians and policymakers was to ground the service and modernise it for the future. However, beyond the NHS's curative medical services, other important developments also took place within public health. Moreover, the expertise applied to health policy that existed within Whitehall and local government underwent change, notably with the rise of new disciplines such as 'health economics' and the inclusion of hitherto unused policy actors such as management consultants.

This chapter traces shifts in health policy across the immediate post-war decades through four themes that might be missed if one just looks for full-scale administrative reform of the NHS, which did not arrive until 1973/74. First, anxieties over costs in the early NHS and the emergence of health economics in policy circles. Second, the construction of medical facilities under the 'Hospital Plan' of the 1960s. Third, public health and the balance between national

and local initiative. Fourth, the novel involvement of management consultants in the eventual administrative restructuring of the service during the mid-1970s.

3.2 Costs, 'crisis', and changing forms of policy expertise

The post-war years were no period of largesse in spending on health, the NHS, or the welfare state as a whole. Though often remembered as a 'Golden Age' of government generosity before the economic crisis of the 1970s and the service's marketisation that followed during the 1980s/1990s, nothing could be further from the truth. In the late 1940s and early 1950s, with significant military commitments to maintain and an empire still to manage, Britain spent almost as much money on the 'warfare state' as on social services.[70] For its own part, the NHS stood as the poorer cousin to other arenas of welfare like education, a position that would not be reversed until 1984.[71] In 1949/1950, NHS spending occupied only 3.5% of GDP, falling to 3.36% in 1960/61, and improving somewhat to 3.86% by 1970/71.[72] Regardless, in financial terms, the service was not treated as a jewel in the crown of the welfare state, and its funding only substantially expanded from the mid-1970s onwards.

All the same, commentators, experts, and politicians in the 1940s and 1950s fretted that too much money was being spent on the health service. The costs of the NHS – and how to manage its resources - captured a great deal of attention in health policy circles. Part of the problem lay in the inaccuracies of the initial estimates for NHS expenditure.[73] When proposing a 'national health service' in 1942, William Beveridge suggested that such a scheme would cost the nation approximately £170 million per annum.[74] The Labour Minister of Health responsible for implementing the service, Aneurin Bevan, predicted that health costs would actually fall over time as the nation dealt with a backlog of ill-health built up due to a prior lack of access to care. Neither prediction came true. After its first year, the NHS was spending almost three times as much as Beveridge's initial estimates. The demand for its services displayed no signs of slowing and the media highlighted, often without systematic evidence, the 'abuse' of the NHS through stories of patients seeking multiple wigs or medicines that they did not need. Organised critics of the health service whipped up anguish about the discrepancies between the original predictions of NHS expenditure and the eventual costs to create an atmosphere of crisis over the seemingly inexhaustible health budget. 'At the present rate of expenditure', warned one critic writing in the *British Medical Journal*, 'it will involve us in national ruin'.[75] Out of these concerns over spending, policies were introduced to contain the budget which resulted in parts of the original NHS legislation falling away. In 1952, for example, the Ministry of Health introduced charges for prescriptions.

As the alarmism about NHS expenditure escalated, the Conservative government established a committee of enquiry in 1953 to consider the costs of the service, chaired by the Cambridge economist Claude Guillebaud. The government hoped that the committee might suggest a number of ways to make savings and bring NHS spending down. Three years later, the 'Guillebaud Report' was published and arrived at quite different conclusions.[76] Contrary to the accusations levelled by the service's critics that it cost too much, the committee showed how health budgets had fallen in relation to GDP since its foundation. Britain, the report demonstrated, actually received good value with the NHS. Other countries, they added, spent more on health.

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70 Edgerton, D. (2018), *The Rise and Fall of the British Nation: A Twentieth-Century History* (Allen Lane), pp. 244-245.

71 Cutler, T. (2006), 'A Double Irony? The Politics of National Health Service Expenditure in the 1950s', in Gorsky, M. and Sheard, S. (eds.), *Financing Medicine: The British Experience since 1750* (Routledge), pp. 201-220; Bank of England Research Datasets (2016), 'A Millennium of Macroeconomic Data', Version 3.1.

72 Hawe, E. and Cockroft, L. (2013), *OHE Guide to UK Health and Health Care Statistics*, 2nd edn. (Office of Health Economics Research), p. 45.

73 Seaton, 'Against the Sacred Cow', especially pp. 430-434.

74 Beveridge, W. (1942), *Social Insurance and Allied Services (Beveridge Report)* (His Majesty's Stationery Office), pp. 103-107.

75 Roberts, F. (1949), 'The Cost of the National Health Service', *British Medical Journal*, 1(293), pp. 293-297, quote on p. 297.

76 National Archives (1956), PREM 11/1492, 'Report of Committee of Enquiry into Cost of Running the National Health Service'.

The statistical evidence for these conclusions resulted from novel techniques in what would later become known as 'health economics' deployed by two men who became internationally-famous experts on social services at the London School of Economics (LSE): the sociologist, Richard Titmuss and the economist, Brian Abel-Smith. Their contributions to the committee – such as aggregating medical services as a 'health system', tying expenditure to GDP, or making comparisons with other nations - underlined the new forms of expertise circulating in health policy as the post-war decades advanced. This approach would have long-lasting implications for shaping health policy by recasting discussions of how much money the nation could – or indeed should – be spending on particular services or medical care overall. In the hands of Titmuss and Abel-Smith, these techniques defended the service's universalist principles from external criticism and went some way to calming the anxieties over health expenditure that permeated the 1950s. What seemed like a crisis in soaring NHS budgets appeared less serious when compared to other government spending or the money allocated to medical care by other countries. Given quantitative rigour, these comparisons took on significant authority.

By the middle of the following decade, however, health economics became deployed by the NHS's critics to highlight a different sort of crisis. The problem, it now seemed, was not too much expenditure on healthcare, but too little. Britain's poor post-war record on funding the NHS – by both Labour and Conservative governments – meant, it was claimed, that the nation was falling perilously behind many international competitors in building new facilities or providing the latest medical technologies. Free-market think tanks and their supporters among the ranks of politicians drew attention to these national imbalances to even argue for the NHS's replacement with a system of private health insurance.[77] If individuals financed their own healthcare through insurance – provided by themselves or their employer, as in many other industrialised nations by this point, including West Germany – then the overall pool of revenue to spend on medical care, they insisted, would be expanded. These arguments gathered pace over the 1970s and came to a head during the early 1980s during Margaret Thatcher's first government when an internal committee in the Department of Health and Social Services was established to consider the feasibility of such proposals. Putting aside these later developments, the immediate post-war decades revealed how rapidly feelings about NHS expenditure could change, how similar forms of expertise could shape contrasting policy proposals, and how a sense of a funding crisis could be deployed to advance contrasting political positions.

3.3 Medical facilities, old and new

Another important arena of health policy concentrated on how to update the nation's stock of medical facilities. The NHS inherited buildings that dated from the interwar, Edwardian, and Victorian past. When the service began in 1948, most hospitals possessed origins in the nineteenth century: approximately forty-five per cent were built before 1891, and twenty-one per cent before 1861.[78] Although we might think today that the start of the NHS symbolised a new dawn (a sentiment shared by some, though certainly not all, members of the public in the 1940s), no new hospitals opened with the inauguration of the service. Given the scant funding given to the NHS – at least, when compared to the late twentieth century - there was little money to spare for capital expenditure once the everyday operational costs were met. As a result, Victorian institutions continued to serve communities across the United Kingdom. Most of these facilities had been established on the back of charitable initiative or began as Poor Law institutions attached to workhouses, as Chapters 1 and 2 demonstrate. The lack of change in the appearance and feel of the NHS, then, challenges the idea of 1948 as a clear watershed in British medicine.

[77] Institute of Economic Affairs (1964), *Monopoly or Choice in Health Services?: A Symposium of Contrasting Approaches to Principles and Practice in Britain and America* (Institute of Economic Affairs).

[78] Ministry of Health (1962), *A Hospital Plan for England and Wales* (Her Majesty's Stationery Office).

Though a full-scale building programme could not be launched by the Ministry of Health at first, other policies reshaped the everyday operation of the NHS's hospitals and doctors' surgeries across the post-war decades. Despite the apparent stagnancy of facilities from the outside, significant shifts were taking place on their wards and in their clinics. The service responded to changing social norms as consumerism and popular affluence swelled, class divides softened, and people thought about sex in different ways. For instance, as attitudes towards extramarital sex loosened somewhat among the wider population, the service began to offer contraception and family planning services more comprehensively. In 1961, the pill became available on the NHS. Six years later, the National Health Service (Family Planning) Act empowered local-authority-funded family health clinics to provide contraceptive advice to unmarried women. In the same year, abortion was legalised through the Abortion Act. These changes did not represent a full-scale sexual revolution that one might associate with the popular image of the 'swinging sixties'. To gain an abortion, for example, a woman still needed approval from two doctors who believed that the birth would harm her mental or physical health, or that the child would be born with significant mental or physical abnormalities. In Northern Ireland, women could not gain an abortion due to local religious opposition to the Abortion Act. The pursuit of NHS modernisation in health policy could, then, prove uneven in its application, as the complications involved in meeting shifts in popular attitudes to gender and sex demonstrates.

By the start of the 1960s, criticism of the NHS's antiquated stock had become impossible to ignore. In 1962, Conservative Minister of Health, Enoch Powell announced a large-scale 'Hospital Plan' which promised a ten-year building programme to construct ninety hospitals throughout England and Wales to the tune of £500 million. It also allocated funds for improving existing facilities, such as constructing a new waiting room or outpatients' ward. Moreover, the Hospital Plan had implications for social care. The 1946 NHS Act had tasked local authorities with the responsibility to provide such services. During the 1960s, these facilities had come under sustained criticism for the standard of care they provided. The sociologist Peter Townsend highlighted many such failings in his provocative study, *The Last Refuge* (1962), which used personal testimonies and photographs of patients to dramatic effect.[79] On the back of such criticisms of long-stay elderly and mental health services, the government signalled support in the 1960s for a policy of 'deinstitutionalisation' that would close many older facilities which dated back to the Victorian era. This shift followed Powell's 1961 'Water Tower' speech where he cast the facilities that cared for the elderly and mentally ill as relics of the past. The Hospital Plan followed this change of direction by envisioning that psychiatric beds in institutions would halve by 1975, and that their patients would be supported by 'community care' instead.

The terms and implementation of the Hospital Plan as a policy reflected a widespread faith in state 'planning' in policy circles in the 1960s, where experts employed by the government marshalled government expertise and resources to meet the nation's existing and projected needs. Such an approach ranged beyond health policy, and shaped housing, infrastructure, industrial strategy, and other realms of economic and social life besides. The Ministry of Health established a new internal Hospital Building Division, for instance, headed by the prominent architect, William Tatton Brown. His division possessed one hundred and twenty architects and produced a series of 'Building Notes' that regional hospital authorities used when formulating their own proposals for construction. On the back of this policy, new NHS facilities began to appear on the edges of towns and cities across the United Kingdom, usually sitting beside their Victorian or Edwardian forebears.

79 Townsend, P. (1962), *The Last Refuge: A Survey of Residential Institutions and Homes for the Aged in England and Wales* (Routledge, Kegan & Paul).

The policy of hospital construction heralded by the Hospital Plan was, nonetheless, not a case of a centralised state dictating to local communities what medical facilities they should build and how to build them. Most architectural policy expertise did indeed lie within the Ministry of Health, and the government possessed final say over local plans. Yet local circumstances and initiative shaped much of the Hospital Plan's implementation on the ground.[80] Regional Hospital Boards (RHB) sometimes used funds in unexpected ways. Sheffield's RHB, for instance, spent over half of their government allocation on upgrading existing facilities rather than building new ones.[81] The government and RHBs also sometimes had to negotiate with local landowners or communities about where hospitals should be built. The design of hospitals in the 1960s and 1970s illustrated local differentiation. Most facilities conformed to modernist architectural aesthetics typical to the post-war welfare state – with concrete structures and flat roofs embodying a distinct style. These hospitals were not seen as grim or imposing but rather an optimistic expression of the medical future. Displaying an attentiveness to local conditions, planners sometimes made adjustments such as lowering a hospital's height to suit the landscape they were constructed in. The NHS was never monolithic, despite repeated claims to this effect later in the century to justify administrative reform (particularly by New Labour politicians).

During the 1970s, difficult economic circumstances in the wake of the 1973 OPEC oil embargo posed obstacles to financing the Hospital Plan. As governments ramped up public spending to offset a downturn, and then abruptly reversed gear, some hospital projects were jettisoned altogether. Modernisation, in terms of new facilities, could not become a completed process in these circumstances. All the same, substantial construction did take place. The state had built only six new NHS hospitals during the ten years after 1956, but seventy-one new hospitals were completed or started over the next ten years. In general terms, considering the NHS's stock of medical facilities between the 1940s and the 1970s underlines the slow pace of the institution's modernisation, but also shows the less-visible signs of change that were also important to transforming the service as a whole. To recognise the modernisation that did take place, then, one also needs to consider the less-obvious shifts in the NHS's use of expertise, its everyday appearance and feel, as well as how practices of care were reshaped by individual policies that might be missed in a search for top-to-bottom administrative reform.

3.4 Public health policy, local and national

This fusion of national coordination and local distinctiveness in health policy can also be identified in the shifting terrain of public health during these years. Under the terms of the 1946 Act, public health remained the responsibility of local councils. In this respect, the legislation extended the long tradition of public health measures – including sanitation measures and vaccination initiatives – being delivered at the community level, as Chapters 1 and 2 above make clear. However, this decision did not entail a total separation from the government, and the two spheres often overlapped with one another. The post-war vaccination campaigns illustrate this point. In the mid-twentieth century, a number of new vaccinations for infectious diseases became available. Accordingly, during the Second World War, the Ministry of Health introduced diphtheria vaccinations for children. Yet it was local Medical Officers of Health (MOHs) who were responsible for promoting these campaigns in their communities and driving up the numbers of families who participated. This pattern repeated itself after 1948 as the policy approach to roll out significant innovations in vaccination – including polio and whooping cough during the 1950s and measles during the 1960s – complemented this blend of national and local initiative.

80 DeVane, E (2021), 'Pilgrim's Progress: The Landscape of the NHS Hospital, 1948-70', *Twentieth Century British History*, 32(4), pp. 534-552.

81 O'Hara, G. (2007), *From Dreams to Disillusionment: Economic and Social Planning in 1960s Britain* (Palgrave Macmillan), p. 187.

As the post-war decades advanced, the meaning of public health shifted in policy discussions and implementation.[82] At the start of the twentieth century, the term carried its earlier connotations of addressing sanitation and infectious disease. To be sure, some measures introduced in the post-1945 era continued within this older tradition. The Clean Air Act 1956 sought to address the longstanding pollution caused by coal and heavy industry, which had come to a head during the 'Great Smog' four years prior. All the same, undeniable transformations within the population altered what public health signalled and, in turn, the discussions about what it was supposed to address. By the middle of the twentieth century, improved nutrition and living standards, alongside medical interventions, meant that people lived longer lives. As a result, chronic conditions – such as cancer or heart disease – became the chief causes of mortality in Britain, as in other industrialised nations.[83] Medical studies in the post-war decades also began to show a relationship between individual behaviour and chronic conditions. One of the most famous was Richard Doll and Austin Bradford Hill's *British Medical Journal* paper that showed an association between smoking and lung cancer.[84] Other studies demonstrated connections between a lack of exercise and coronary heart disease, including research by Jerry Morris that pointed to how 'ways of living' shaped health outcomes.[85] Public health officials, then, needed to address a different landscape than their interwar forebears.

Health policy attempted to move in tandem with these changing epidemiological trends and novel avenues of medical research. Different patterns of disease warranted a new approach to health education, which targeted the parts of the population that medical experts deemed most at risk. This strategy meant that certain groups became the focus of attention over others – particularly working-class people and women. For instance, initiatives aimed to reduce smoking during the 1960s suggested to working-class people that their money would be better spent elsewhere. One Ministry of Health poster from 1966 titled, 'More money, more fun if you don't smoke' displayed a young man surrounded by the new consumer goods available to people of his generation.[86] This poster's focus on an imagined working-class youth followed the medical research that often showed a disproportionate level of disease among poorer Britons due to their 'lifestyle' choices. Its appeal to the leisure activities of the working-classes, as well as changing ideas of masculinity which might prioritise consumerism, demonstrated how health education could adapt to the changing cultural dynamics of the post-war period.

Policies to construct health centres offered another possibility of addressing the distinct challenges of the post-war era. Beginning in Britain during the interwar years with pioneering sites such as the Finsbury Health Centre and the Pioneer Health Centre in Peckham, these facilities brought together GPs, nurses, dentists, social workers, and public health officials under one roof. The NHS Act stipulated a network of such centres would be constructed across the country as national policy. Given the limited funds allocated to the service, and some doctors' opposition to being grouped together in such a way, this grand ambition was quickly shelved. However, a number of 'experimental' health centres did become established in the 1940s and 1950s, often on the back of initiative from enterprising local doctors or from philanthropic organisations such as the British Nuffield Trust and the U.S. Rockefeller Foundation.[87] In these new facilities, GPs used consulting rooms and local councils organised public health clinics in a sign of what was possible through coordination.

82 Mold, Clark, Millward and Payling, *Placing the Public in Public Health in Postwar Britain*, pp. 16-17.

83 Weisz, G. (2014), *Chronic Disease in the Twentieth Century: A History* (Johns Hopkins University Press).

84 Doll, R. and Bradford Hill, A. (1950), 'Smoking and Carcinoma of the Lung', *British Medical Journal*, 2(4682), pp. 739-748; Berridge, *Marketing Health*.

85 Morris, J.N. (1957), 'Uses of Epidemiology', *British Medical Journal*, 2(4936), pp. 395-401.

86 This poster is discussed in Mold, Clark, Millward, and Payling, *Placing the Public in Public Health in Postwar Britain*, pp. 56-57.

87 Seaton, A. (2020), 'The Gospel of Wealth and the National Health: The Rockefeller Foundation and Social Medicine in Britain's NHS, 1945-60', *Bulletin of the History of Medicine*, 94(1), pp. 91-124.

These experimental facilities were primarily based in urban communities such as London, Edinburgh, Manchester, and Harlow, and kept the health centre idea alive until it could be advanced more comprehensively from the mid-1960s onwards. After the Labour government of Harold Wilson signed a 'Doctors' Charter' with GPs in 1966 – which promised, among other benefits, financial support for GPs to hire nurses, receptionists, and other workers – health centres expanded dramatically in number. If just twenty-four health centres opened across the United Kingdom in the first twelve years of the NHS, there were 1378 centres by 1984.[88] Post-war NHS modernisation was now shaping the everyday world of general practice and providing new inroads for public health.

Yet the slow pace of growth in health centres revealed, in many respects, the difficulties that public health faced in the post-war era. To some, public health was something of a 'Cinderella service' given little serious thought by civil servants, politicians, and the medical profession.[89] Local Medical Officers of Health (MOHs) sometimes struggled to find a purpose or to navigate the complexities of an NHS that seemed more interested in hospital care, a suspicion confirmed by the allocation of budgets and prestige. In this view, the nationalised system seemed more of a 'sickness service' than a truly 'health service'. Although these accusations might have overstated the shortcomings of public health – which did enjoy some successes in places like health centres - its peripheral status formed part of the arguments for wholescale administrative reform of the NHS that gathered pace in the late 1960s and thereafter occupied a significant deal of policy discussion.

3.5 1973-1974: the first systemic reform of the NHS

The original structure of the NHS, though often widely praised in expert circles at home and abroad at the point of its foundation, possessed a key weakness: the administrative barriers between hospital, GP, and local authority public health services.[90] The problems of this tripartite split were manifold, including a lack of communication between the three branches of the service and the continued predominance of the hospitals at the expense of family doctoring. By the 1960s, these criticisms reached fever pitch and administrative reform became widely discussed in policy circles. Both the Labour and Conservative Party agreed that the NHS needed to be reorganised so that a unified health and local authority system could become a reality. The various green papers put forward by the Ministry of Health between 1968 and 1974 showed a remarkable degree of consensus between both parties on this point. However, the medical profession – which had long harboured opposition to being controlled by local councils – shut down the possibility of health services once again being transferred to local government. The compromise solution emerged as the establishment of 'area boards' within the NHS that would coordinate the three branches of the service under a revamped management structure.

When designing the terms of what would become the 1973 National Health Service Reorganisation Act, the Conservative government recruited a novel form of policy expertise: management consultancy.[91] For the first time, management consultants would help shape a high-level reorganisation of the NHS. The reasons for hiring the services of McKinsey & Co – which, like other U.S. management consultants had made inroads into Europe from the 1950s onwards - ranged from their established reputation in the field of healthcare, a belief that they would bring an 'entrepreneurial' U.S. approach, and a sense that there was insufficient expertise within the civil service itself. By the 1970s, then, the faith in state planning evident in earlier policies such as the Hospital Plan had dimmed somewhat. Private companies and expertise, some politicians seemed to agree, could perhaps make a valuable contribution to policymaking

88 MMI Publications (1984), *The Directory of Health Centres* (MMI Publications), p. 421.
89 Lewis, J. (1986), *What Price Community Medicine? The Philosophy, Practice and Politics of Public Health Since 1919* (Wheatsheaf).
90 Klein, *The New Politics of the NHS*, 7th edn. pp. 66-71.
91 Begley and Sheard, 'McKinsey and the 'Tripartite Monster', pp. 390-410.

alongside traditional forms of expertise drawn from the public sector. This process gathered pace in later decades, as Chapter 4 discusses. At a cost of between £6000-£10,000 per month, McKinsey produced a report which detailed each tier of the new NHS and the responsibilities of new management roles. In 1974, the new legislation came into effect.[92] It abolished the NHS's original Regional Hospital Boards (RHBs) and replaced them with fifteen Regional Health Authorities (RHAs) and ninety Area Health Authorities (AHAs) which were responsible for the planning and delivery of services in a more coordinated fashion. Public health functions and community health services were transferred to the AHAs. The 1973 Act created a new NHS structure, which – at least on paper - better established the principles of integration and managerialism than the legislation which founded the service.

However, for all these good intentions and the high degree of consensus between political parties on reorganisation, the 1973-74 policy was widely deemed to be a failure. Critics quickly rounded upon it for being too managerialist. To many, the implementation of multiple tiers of authority also seemed byzantine. McKinsey's contributions were critiqued and raised questions about not just the expense of relying on management consultants for health policy, but also issues of accountability. Conservative Secretary of State for Health, Kenneth Clarke, later lambasted their involvement and what he recalled as the 'stupid McKinsey report'. The role of consultants in NHS policy would only become more extensive and controversial over time.

However, some important principles of later health service development were introduced through the 1973 Act, particularly around the issue of patients' rights. The legislation established Community Health Councils (CHCs) for each AHA which were tasked with a range of responsibilities including sourcing views on services, representing the interests of groups and individuals to planners, highlighting gaps in provision, and promoting public health. Moreover, the Act established the Health Service Ombudsman, a role which investigated NHS bodies on behalf of 'consumers'. Though these attempts to embed patient power within the NHS did not fully translate into success, they signalled at least a desire to democratise a service that had included no such formal mechanisms at the point of its inception.

3.6 Conclusion

Given the economic crisis, the first half of the 1970s were difficult years for ambitious health policy initiatives. The 1973 NHS Reorganisation Act largely disappointed. However, a focus on wholescale restructuring of the nationalised service – which only took on such importance after this legislation – obscures the significant policy transformations that had taken place over the previous twenty-five years. The NHS survived the alarmism over its budgets and in fact enjoyed healthier funding from the 1970s compared to the supposed golden age of welfare in the 1940s. New hospitals were constructed, and old ones were upgraded. Local communities gained widening access to facilities such as health centres. Inside its clinics and on its wards, the NHS exhibited an adaptiveness to changing social attitudes. While public health struggled to secure a central position in health policy, it underwent a shift in emphasis towards the prevention of chronic disease that would be taken more seriously as the decades progressed. However incomplete or uneven, the period between 1948 and 1974 should be recognised as an important period of modernisation in the NHS, shifts in public health, and the emergence of new forms of expertise that would carry significant influence in health policy in the years to come.

92 Her Majesty's Stationery Office (1973), *National Health Service Reorganisation Act*, 1973 (Her Majesty's Stationery Office).

Chapter 4: British health policy, 1974-2022

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Key messages

Key shifts in health policy occurred in 1991 (the NHS internal market) and 2012 (the Health and Social Care Act). The latter was a consolidation of a long-term political trajectory towards greater marketisation of the NHS. This was first articulated during the Thatcher government, but not discontinued by the 1997-2010 Labour government.

The dislocation between health and social care, and also between the NHS and public and environmental health, has been an enduring disadvantage for the planning and delivery of efficient and effective services since the creation of the NHS in 1948. No government has been willing to fully grasp this nettle.

Where health policy was made, and by whom, shifted considerably between 1974 and 2022. Governments have experimented with divorcing the NHS from the Department of Health and Social Care (and its predecessors the Department of Health and Social Security: 1968-1988, and the Department of Health: 1988-2020) through the creation of 'arms-length-bodies' and independent statutory bodies such as the NHS Management Executive, the National Institute for Health and Clinical Excellence (NICE), the Care and Quality Commission (CQC), and NHS England.

Public health, especially through health protection policies, has also reflected changing cultural views on the balance between individual and societal rights and responsibilities. The neoliberal mission to 'shrink the state', particularly between 1979 and 1997, and again from 2010, tempered the adoption of policies that could address health inequalities.

The public's opportunities to contribute to health policy have varied over the period, from Community Health Councils via Public and Patient Involvement Forums to Healthwatch, focus groups, and citizens' juries. However, their impact remains subordinate to other types of expertise, especially economic and medical.

The COVID-19 pandemic exposed the tension in health policymaking between politicians and their scientific advisers. It also highlighted the weaknesses in the public health system, especially collaboration between local government teams and Public Health England. The decision to reform public health agencies midway through the pandemic appeared to be another short-term political decision.

4.1 Introduction

Policies focused on health are now some of the most overtly politicised, and publicised, in the UK. Yet in 1974, when the NHS was first reorganised, having operated unchanged for 26 years, it merited virtually no coverage in the media. This chapter covers a substantial period but is underpinned by a consistent driver: the search for efficiency and effectiveness in the delivery of healthcare to meet public and political expectations of what can be achieved within a 'universal health coverage' (UHC) system. The period opens with a change from a Conservative to a Labour

government, which came to power with a manifesto to remove the last vestiges of private medicine from within the NHS. It ends with a Conservative government grappling with how to maintain the façade of a 'national' system, which has strong public resonance, but behind which many commercial organisations now deliver core activities.

The NHS is at the heart of, but not the entirety, of British health policy. Yet, despite initiatives such as 'health in all policies' reviews, it has continued to dominate how governments have approached both personal and population health. Most of the reviews, papers and legislation since 1974 have acknowledged an economic imperative to manage the rising cost of healthcare, and its close associate social care. As a UHC system, funded through central financial mechanisms, it has proved almost impossible to manage independently from the national 'budget'. Governments of all political persuasions have entertained proposals for changing the funding model and varying levels of 'marketisation/privatisation'.

This chapter is structured around the core theme of the tension between rising costs of health and the public and political responses. It explores key levers through which these tensions have been managed, especially 'reform' – a term first seen in the foreword to the 1989 White Paper *Working for Patients*, but which has been latent in the increasingly frequent manipulations of the NHS since 1974. It highlights how the processes behind policy development and health service governance have changed, with a cumulative progression from a small, closed network of senior Whitehall policymakers to a more permeable coalition of interested parties that has drawn expertise from increasingly influential sources such as thinktanks and management consultancies via individuals who move smoothly and frequently between them, the civil service, and the NHS.

Has structural change of the NHS had an impact on health in Britain? This is a question which governments have been cautious in approaching directly. Some of the reforms have engaged with concepts such as health determinants and acknowledged that achieving and maintaining health requires more than a national medical service. There have been some significant studies of the role of public health and its capacity to address health inequity, such as the Black Report, the Acheson inquiry, and the Wanless and Marmot reviews, that have had variable impact. Governments have also responded to some significant shifts in scientific knowledge, such as the role of genes and the immune system. Yet, the intellectual and cultural bedrock for health policy remains the authority of medicine and the medical profession. Governments have been slow to adapt formal governance systems to acknowledge and incorporate the public voice – either through individual consultations or as patient activist groups, yet are apparently open to influence by more powerful vested interests such as global corporations for pharmaceuticals, food, and social media.

4.2 Who really makes health policy?

Despite increasing talk about 'policy', there remains a surprising naivety about how it gets made, and by whom. It is helpful to also acknowledge that it is broader than the usual focus on legislation or directives which are the most visible elements of the policy process. It is harder to 'see' the micro-level decision making by individuals within the system, which sometimes are contradictory.[93] The emergence of a new academic area within political science since the 1970s has provided tools to open up a dialogue with policymakers on critical issues such as what is 'effective' or 'evidence-based' policy. The belief in a linear process from identification of problem to collation of evidence to policy solution has been usefully disrupted, at least in academia. Models such as John Kingdon's 'multiple streams' analysis and Carolyn Hughes Tuohy's 'big bangs, blueprints, mosaics and increments' framework illuminate the points in political cycles at which politicians feel they have the mandate and confidence to attempt

93 Cairney, P. (2015), *The Politics of Evidence-based Policymaking* (Palgrave Macmillan).

the introduction of new policies, and where the entry points for expert advice could/should be, if evidence-informed policy is still deemed the preferred model.[94] The public appears to continue to support policymaking based on robust expert advice, even if there are subsequent trade-offs, which may also require some use of values in decision-making for vital support systems, such as the NHS.

The policies that are encoded through legislation, such as acts of parliament and command papers, are the responsibility of the political incumbent of the senior office in the Whitehall department or ministry – the Secretary of State. They are advised by civil servants, who do not offer an assessment of previous government approaches, but who provide an institutional memory that politicians may (or may not) choose to call on. Attempts at organisational learning, especially from crises such as Bovine Spongiform Encephalopathy (BSE) or the Mid-Staffordshire hospital scandal, have been patchy.[95] Prime Ministers have also exercised a degree of flexibility in the extent to which they have left their Secretaries of State to set the health policy agenda and determine how it interfaces with other key areas of governments, such as social care and environment. The length of tenure for the 33 Secretaries of State for the Department of Health (and Social Security/Care) since the creation of the NHS in 1948 ranges from Jeremy Hunt (five years and ten months) to Therese Coffey (seven weeks), the latter significantly pulling the average down to 27 months. During the period this chapter covers there have been 23 incumbents, including the latest, Steve Barclay. Most of them have been content to leave the health service delivery side to managers once their preferred structures have been established, but with some notable oscillations between centralisation and decentralisation of decision making.

4.3 1974-1997: from 'peak welfare' to 'marketisation' of health

When Barbara Castle became Secretary of State for the Department of Health and Social Security (DHSS) in March 1974, the NHS was less than a month away from its first major reorganisation. There was an immediate decision to be made – continue or halt? She continued, but in full knowledge that the new system was not a significant improvement on the former one. It failed to remedy the dislocation of health and social care or improve management. In 1976, a Royal Commission on the NHS was announced, reporting in 1979 after the election of a Conservative government under Margaret Thatcher. The commission's main recommendation of removing a layer of bureaucracy chimed with the new political philosophy of 'shrinking the state'. The regional health authorities were now supplied with data on their activities through the Hospital Episode Statistics system, and new economic tools such as cost-benefit analyses supported early attempts to measure 'value for money'. The cost of the NHS was £3.1 billion in 1974 (3.7% of GDP), increasing pressure for a fairer budget distribution, which was achieved through RAWP – the Resource Allocation Working Party formula. The DHSS, which held the purse strings for the NHS regions, instituted a programme budget, for the first time planning an annual percentage increase for new medical technologies and the costs of care for an ageing population.

The direction of travel towards greater efficiency in the use of NHS resources intensified, with Thatcher taking a personal interest, famously declaring during a TV interview that 'the NHS is safe in our hands'. She brought in Roy Griffiths, a director of Sainsbury's supermarket chain, to lead an NHS Management Inquiry in 1983. Griffiths recommended the creation of an NHS Management Board, a post of NHS Chief Executive, and the introduction of general managers at all levels – a firm shot across the bows of the medical profession who had previously enjoyed unhindered clinical autonomy.

94 Kingdon, J. (1995), *Agendas, Alternatives, and Public Policies* (Harper Collins); Hughes Tuohy, C. (2018), *Remaking Policy. Scale, Pace and Political Strategy in Health Care Reform* (University of Toronto Press).

95 For the report of the public inquiry launched into the Mid Staffordshire NHS Foundation Trust, see (2013), *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, Her Majesty's Stationery Office.

Thatcher and her policy advisors were exploring alternative funding models for healthcare before they came into government. They looked especially to the US, where the public welfare systems of Medicare and Medicaid exemplified a more basic state support ethos, with the majority of citizens contributing substantial amounts to the costs of their care through private medical insurance. A logical step on this road would be to introduce an element of competition into the NHS by splitting purchasers (primary care/GPs as budget holders on behalf of patients) and providers (secondary care/hospitals) to drive efficiency gains. With advice from Alain Enthoven, a US economist, and from UK health economists such as Alan Maynard, Kenneth Clarke, the Secretary of State for Health, developed a blueprint for an NHS Internal Market, in the face of fierce opposition from the British Medical Association (BMA), the main trade union for the medical profession. There was no political option of running a pilot: it was all or nothing because, as Clarke said to John Marks, chair of the BMA: 'You buggers would sabotage it'.[96]

With the creation of the NHS Internal Market, operationalised through NHS trusts, policy development appeared locked into a progressive 'marketisation', which opened-up the potential for non-NHS bodies to bid for contracts through the new commissioning process. Political enthusiasm for true competition in the supply of healthcare, however, was strictly limited by the necessity of ensuring no hospital went bankrupt for lack of contracts. Instead, the NHS operated a 'shadow' or 'internal' market. Some catering, cleaning, and laundry services had already been contracted-out since the 1980s, and in the 1990s the NHS increasingly used private hospitals.

The ability of the NHS to acknowledge and address health determinants and inequalities in this era was hindered by the dislocation of personal from public health. Although the 1974 reorganisation brought public health into NHS health authorities (and renaming Medical Officers of Health as Community Physicians), the partial union with primary and secondary care was stymied by a weakened relationship with environmental health, which remained with local government. The wider determinants of health were already well known but not effectively articulated in policy. In 1976, the DHSS published a brief report, *Prevention and Health, Everybody's Business* that identified some areas for intervention including heart disease, road traffic accidents, smoking-related diseases, alcoholism, mental health, illicit drugs, and sexually transmitted infections (STIs). It was seen as a rushed response and failed to gain policy traction. Yet, the rising costs of the NHS provided an impetus to look more closely at factors beyond medical care, such as income, housing, diet, and exercise – later to be brought together under the 'social determinants' label. The 1974-79 Labour government also commissioned a review of health inequalities led by Sir Douglas Black, the Chief Scientist. This thorough study demonstrated that death rates for some diseases such as cancers and heart disease were significantly higher in the social classes IV and V (semi-skilled and unskilled labour), with substantial, increasing regional inequalities (a north-south divide had long been evident). The report's authors concluded that the gap was due to issues such as 'income, work (or lack of it), environment, education, housing, transport, and "lifestyles". It briefly acknowledged that there were also race and ethnicity-related health inequalities and drew attention to the lack of data on the growing overseas-born population and how their specific health needs were provided for by the NHS.[97] The majority of the 37 recommendations were not directly to do with health or healthcare but aimed to restore eroded welfare benefits and invest in pre-school support. In policy terms the evidence was persuasive, but the report was delivered in 1980 to the new Conservative government, which had little appetite for addressing the factors highlighted. The new Secretary of State for Health and Social Security, Patrick Jenkin, wrote a foreword noting that the estimated cost of £2 billion a year was 'quite unrealistic in present or any foreseeable economic circumstances'.

96 Mackillop, E., Sheard. S., Begley, P. and Lambert, M. (2018), *The NHS Internal Market. A Witness Seminar Transcript* (University of Liverpool), p. 47.

97 Townsend, P. and Davidson, N (eds.) with Whitehead, M. (1988), *Inequalities in Heath: The Black Report and the Health Divide* (Penguin), p. 2.

The public health and health inequalities agenda may have stalled in the UK, but there was growing international momentum. In 1978, the World Health Organization (WHO) issued a declaration on the role of primary healthcare at a conference held in Alma-Ata, USSR. This initiated an ambitious strategy called 'Health for All by the Year 2000', launched in 1981, which identified targets for key health indicators, such as smoking cessation, reducing alcohol consumption and increasing vaccinations. In 1986, the Ottawa Charter further shifted the focus of public health from disease prevention to 'capacity for building health'. Despite pressure from leading experts, and requests from local government, no UK health strategy was planned. Studies by the Kings Fund and the Institute of Public Policy Research criticised the government's 'unhealthy concentration on health services'.[98]

Professional associations found routes to maintain the visibility of public health by submitting evidence to parliamentary committees, and public health was increasingly multidisciplinary, with job opportunities for those without the traditional medical qualification. The Public Health Alliance was formed in 1987 to bring together these groups, including single issue pressure groups such as Action on Smoking and Health (ASH). During the impasse, many local authorities and NHS bodies decided to make their own progress. Wales published its health strategy in 1989, and Scotland and Northern Ireland followed soon after. Some cities, such as Liverpool, also signed up to the WHO Healthy Cities movement, launched in 1986. Finally, in 1991, the UK government engaged with this global movement through its own *Health of the Nation* strategy green paper, which aimed at securing the continuing health of the population through 'adding years to life (increasing life expectancy and reducing premature death) and by 'adding life to years' (improving the quality of life and reducing illness). It identified five areas, subsequently formalised through a white paper which outlined how different agencies would help address cancer, heart disease/stroke, mental illness, HIV/AIDS and sexual health, and accidents. These disease-based targets were robustly criticised, as well as the failure of health authorities to fully engage with the strategy. The government's blinkered views on the capacity and potential for local authorities to support public health was evidenced by its failure to send them copies of the white paper. Its emphasis on disease rather than environmental and socio-economic factors also made it difficult for local authorities to engage. Reviews by the Public Accounts Committee found little progress against the objectives and the promised central coordination failed to emerge.

Despite turning a political blind eye to rising health inequalities (to the extent that the term 'inequalities' was replaced by 'variations' in all government publications), there was a recognition of the need to maintain expertise on health protection, specifically for emerging infections. For example, rapid policy responses were required in mid-1980s for HIV/AIDS, and Thatcher and her Secretary of State for Health and Social Services, Norman Fowler, were relieved to be able to call on the Chief Medical Officer Donald Acheson, despite the 'shrunken' medical civil service in the Department of Health (split in 1988 from Social Security). His successor, Kenneth Calman, inherited the growing crisis around BSE, better known in the media as 'mad cow disease', with even fewer resources. His summary of these when asked at the official inquiry was 'my secretary and a mobile phone'.[99] In other areas, it was economic expertise, not medical, that was increasingly sought and applied, for example, to justify the introduction of screening programmes for breast cancer in 1988, the first of several diseases to be addressed in this way. The development of an analytical tool to measure the benefit of treatments – the Quality Adjusted Life Year (QALY) – also transformed approaches to resource allocation by greatly facilitating health technology assessment.

98 Harrison, S., Hunter, D., Johnson, I., Nicholson, N., Thunhurst, C. and Wistow, G. (1991), *Health Before Health Care,* Social Policy Paper No.4 (Institute of Public Policy Research), p. 3.

99 Sheard and Donaldson, *The Nation's Doctor.*

The public's engagement with health policy was carefully curated. Community Health Councils (CHCs) were created in 1974 to provide a mechanism for expressing views on NHS services, but not necessarily for soliciting opinions on how to improve them. The public were more commonly 'spoken to' rather than 'with', as seen through the AIDS: Don't Die of Ignorance public information campaign. But if the NHS was to become 'marketised', the patient would have to become the 'consumer' and be guided in how to exercise choice to drive system improvements.[100] Patients' rights were codified through the 1991 Citizen's Charter, but this failed to address problems such as coordination of health and social care, and the specific support needs of individuals with disabilities and carers. Black, Asian, and minority ethnic communities continued to be marginalised in terms of their health needs. An Immigrant Mortality Study was conducted in 1984 but was limited in scope. Although it raised issues such as high stillbirth and perinatal mortality in births to mothers of South Asian origin, the NHS was slow to respond with initiatives such as non-English language support services.[101] Yet, the NHS was employing an increasingly ethnically diverse workforce. In the late 1970s, between 18,000 and 20,000 registered doctors were born outside the UK, with half of these being from India or Pakistan. There were also steady increases in Black, Asian, and minority ethnic nurses, especially from the Caribbean, Africa, India, and the Philippines, raising ethical concerns about the impact on health service provision in low-and middle-income countries.[102]

4.4 1997-2010: same path, more resources?

Labour had been in the Westminster waiting room for eighteen years. Yet, when Tony Blair rang Alan Milburn just before the election, he reportedly told him 'we haven't got a health policy. Your job is to get us one.'[103] The arrival of a Labour government in 1997 might have been expected to review and reverse the 'marketisation/privatisation' strategy. Yet, they signalled that although the terminology might change from 'internal market' to 'integrated care', the structures would remain, with the exception of GP fundholding, always the most politically divisive aspect of the internal market. There was support from across government for a return to a holistic vision of health, through initiatives such as Sure Start – led by Gordon Brown at the Treasury – that acknowledged that good health started before birth and required joined-up approaches involving education and housing. Blair was keen to promote partnership, especially between the NHS and local government, and this was operationalised through joint appointments, joint investment plans and the creation of Health Action Zones. Local authorities gained wider powers to improve the wellbeing of neighbourhoods and to develop community strategies. The commitments to a national minimum wage and raising benefits were also important in addressing wider health determinants.

Labour's 'Third Way' philosophy attempted to square the circle of both state intervention and greater individual responsibility for health. It refreshed its policy approach through a green paper *Our Healthier Nation* in 1998 and a white paper *Saving Lives: Our Healthier Nation* in 1999. This talked of a 'new contract' between the state and the individual but maintained the disease-based target strategy. It gave local authorities useful tools such as more robust planning processes and supported their work through a new Health Development Agency (which replaced the Health Education Authority). Each region was to benefit from a public health observatory, linking academics into local health policymaking processes. The government also created a new ministerial position for public health (the first incumbent was Tessa Jowell), but this did not come with a Cabinet seat – a missed opportunity.

100 Mold, Clark, Millward and Payling, *Placing the Public in Public Health in Post-war Britain*.

101 Marmot, M., Adelstein, A.M. and Bulusu, L. (1984), 'Immigrant Mortality in England and Wales, 1970-1978: causes of death by country of birth', *Office of Population Censuses and Surveys, Studies on Medical and Population Subjects, No.47* (Her Majesty's Stationery Office).

102 Simpson, J., Esmail, A., Kalra, V. and Snow, S. (2010), 'Writing migrants back into NHS History: addressing a 'collective amnesia' and its policy implications', *Journal of the Royal Society of Medicine* 103(10), pp. 392-396.

103 Timmins, N. (2017), *The Five Giants: A Biography of the Welfare State* (William Collins), p. 589. Quoting an interview with Alan Milburn.

Yet, Labour seemed unprepared for managing chronic issues such as the size of the NHS waiting list. Introducing performance management through target setting and initiatives such as 'Payment by Results' sat awkwardly with pledges to increase local autonomy. NHS costs were now £44.5 billion (4.6% of GDP), driven by more expensive medical technologies, such as new drugs for cancers and rare diseases, as well as by an ageing population who experienced more years with co-morbidities. The R word – 'rationing' - had never been part of NHS parlance, but the government now needed a way to make choices on what was affordable without the associated political fall-out. The National Institute for Health and Clinical Excellence (NICE) was established in 1999 to review the cost effectiveness of new treatments before they could be approved for use in the NHS. Despite an initial media furore over drugs such as Herceptin (for breast cancer), a careful communications strategy with the public, the medical profession and the pharmaceutical industry calmed fears and positioned NICE as a logical development of the evidence-based-medicine (EBM) approach, pioneered through the Cochrane Collaboration.

NICE was one of several new 'arms-length-bodies' whose purpose was to differentiate policy development from service delivery, including the Commission for Health Improvement (CHI). There had been earlier structures created to operationalise this, including the NHS Management Board in 1985, (later reconfigured as the NHS Executive in 1994). Practically and symbolically, the policy/delivery separation had also been reinforced by the relocation of the NHS Management Board/Executive from Whitehall to Leeds. This was abolished in 2002 and its functions taken back into the Department of Health. NHS leadership within the Department, until the creation of NHS England in 2012, now rested with a new role, the NHS Medical Director, achieved through a re-working of the CMO's portfolio. Bruce Keogh and Liam Donaldson, as the respective incumbents, appreciated the need for a clear command structure.

The policy trajectory for the next phase of Labour's government was set out in 2000 in the NHS Plan, a ten-year strategy led by the new Secretary of State for Health, Alan Milburn. This was supposed to have a more inclusive development process but in practice it held fast to a top-down change model, initiated and led by central government. The reconfiguration to Strategic Health Authorities in 2002 (replacing the Department of Health regional offices, health authorities and primary care groups) reshuffled many of the same staff. Some senior staff left to join the burgeoning consultancy firms that now tendered for work on implementation strategies. By now it was almost impossible to embark on any policy development without involving management consultants – a sign of how the 'Westminster model' had embraced the 'New Public Management'. The rising costs of consultants triggered alarm bells with the National Audit Office which estimated that the NHS was spending more than £600 million a year on their services. Information Technology (IT) specialists were a significant cost for trusts, battling with how to link electronic patient records across disparate NHS systems.

Tony Blair did commit to finding more resources for the NHS, announcing on Sunday 16 January 2000 on the BBC's flagship programme 'Breakfast with Frost', that he would raise its budget to the European Union average share of GDP by 2005 – dubbed by Nick Timmins 'the most expensive breakfast in history'. The government later announced a longer-term assessment of health determinants and costs of care and asked the businessman Derek Wanless to lead this, who delivered the *Securing our Future Health* report in 2002, and a follow-on report in 2004, *Securing Good Health for the Whole Population*, that highlighted the need for more attention to community care and social care, especially for older people. Prevention policies needed to address not only the known causes of ill-health, such as tobacco smoking (a ban on smoking in public places was introduced in 2007), but also the more intangible factors behind rising levels of obesity and diabetes. The public were now consulted via Public and Patient Involvement Forums – a muted version of the Community Health Councils that were abolished in 2003 - on how they wished to make decisions on their own health, a recognition that British culture had changed, but this was hard to reconcile with strengthened evidence that it was structural determinants of health (income, housing, etc) that limited healthy individual lifestyle choices.

Yet, the political focus remained firmly on symptoms of system malaise, such as rising NHS costs. In 2008, when the annual NHS budget broke the £100 billion threshold (6.4% of GDP), the Care Quality Commission (CQC) was established as an independent regulator for both health and social care, and a series of initiatives were launched to achieve efficiency savings of £15-20 billion by 2014-15 (the 'Nicholson challenge'). Despite more frequent flirtations with non-NHS providers, such as the use of private hospitals for waiting list initiatives, the government remained firmly committed to the NHS as the main provider of healthcare, funded through central taxation.

By the end of the thirteen-year Labour administration there had been significant improvements to the NHS – from increases in staffing (nurses by 30% and GPs by 9%) to reductions in waiting lists. For patients, the experience had also improved, with a reduction in hospital-acquired infections (a benefit of taking cleaning back 'in-house' by some NHS trusts), and better outcomes for those diagnosed with cancers and heart disease. Life expectancy had increased and was now matched by a similar increase in number of years of disability-free life expectancy.[104] In England, social class and regional variations in life expectancy, which had widened between the 1970s and the 1990s, were reversed through an overt health inequalities strategy that included innovations such the introduction of the national minimum wage, as well as increased social investment in more deprived areas and population groups. Related measures of Labour's welfare strategy showed similar trends, for example, a reduction in pensioners living in poverty from 20% to 14%, and a halving of the number of children living in poverty to 1.1m.[105] There was more to be achieved, and achievable, as set out in the 'Fair Society, Healthy Lives' study led by Michael Marmot that reported in 2010, including addressing health inequalities of Black, Asian, and minority ethnic groups for which there was very little data collected.[106]

4.5 2010-2020: whose health is it anyway?

The incoming coalition Conservative/Liberal government in 2010 moved quickly to return to an agenda of 'shrinking the state'. The NHS budget had grown to £119.9 billion (7.4% of GDP), although it was rated as one of the most cost-effective systems in the developed world. David Cameron and his new Secretary of State for Health, Andrew Lansley, already had a blueprint for radical reform. Less than a year after coming into office, the government introduced the 2011 Health and Social Care Bill. There was no planned public or professional consultation on the proposals to open-up NHS delivery to 'any willing provider', and the outrage should not have come as a surprise, given the public's affection for the NHS. Cameron called for a pause during which an independent forum scrutinised the bill, but when it resumed it had a difficult passage through both houses of parliament. It appeared to threaten the end of the NHS as a UHC system, and with that an attack on British values of altruism and risk sharing.

The Health and Social Care Act received royal assent in 2012. It created NHS England as an independent statutory body to take responsibility for delivery of healthcare outside of the Department of Health again, and replaced Primary Care Trusts (PCTs) with Clinical Commissioning Groups. These became operational in 2013, along with the CQC, which also provided the formal route for patient engagement through Healthwatch England, and Public Health England (PHE) as executive agencies. Public Health returned to local government, from which it had been removed in 1974.

104 Smith, P. (2008), 'Chapter 6 England: Intended and Unintended Effects', in Wismar, M., McKee, M., Ernst, K., Srivastava, D. and Busse, R. (eds.) *Health Targets in Europe: Learning from Experience*, Observatory Studies Series, no. 13 (WHO Regional Office for Europe).

105 Barr, B., Higgerson, J. and Whitehead, M. (2017), 'Investigating the impact of the English health inequalities strategy: time trend analysis', *British Medical Journal*, 358(j3310).

106 Marmot, M., Allen, J., Goldblatt, P. Boyce, T., McNeish, D., Grady, M. and Geddes, I. (2010), *Fair Society, Healthy Lives: the Marmot review; strategic review of health inequalities in England post 2010*. *The Marmot Review*, Strategic Review of Health Inequalities in England post-2010. Institute of Health Equity.

Yet, the divergence between forecasted and actual healthcare costs continued to grow, stimulating political pressure for 'in-plan' reform. In 2014, the Chief Executive of the NHS, Simon Stevens, launched the Five Year Forward View. The objective was to support decentralisation to place-based planning and delivery of integrated health and social care with a renewed focus on prevention. New organisations – 44 Sustainability and Transformation Partnerships (STPs) were created to bring together NHS trusts, commissioners, and councils at the local level. By such means Stevens quietly side-lined the internal market, in apparent contradiction to Lansley's policies. Specific challenges with the GP workforce were addressed through a 'new deal', and NHS Improvement was created to simplify the regulatory landscape. Further efficiency reviews focused on historic clinical practices, such as provision of routine treatment in hospitals at weekends, but failed to engage with the elephant in the room of delayed discharges due to problems with social care, for which costs were also rising beyond political comfort zones.

Politicians committed to some regulatory measures such as introducing a soft drinks levy in 2016 to tackle rising levels of obesity, which was known to be associated with significant multi-morbidities including cancer, but this was a sop compared to what could be achieved through a more joined up strategy for health protection/prevention. Another public health policy proposal with a strong evidence base – the introduction of a minimum alcohol unit price - was only taken up by one of the devolved nations, Scotland (Scotland and Northern Ireland had autonomous NHS systems from 1948; devolution in 1999 gave NHS Wales a similar status). Initiatives to tackle air pollution were flagged but not actively pursued until the UK government was threatened with legal action. Mental health remained on the policy starting blocks, despite several well-intentioned reviews. In 2015, the Welsh government did successfully pass an innovative piece of legislation designed to require all public bodies to actively pursue the economic, social, environmental, and cultural wellbeing of the country. The Wellbeing of Future Generations (Wales) Act put the creation of a 'healthier Wales' as one of its seven objectives, to be addressed through strategic aims of longer-term planning, prevention, integration, collaboration and involvement.

Rising life expectancies across the UK that had been sustained almost unbroken since the start of the NHS in 1948 began to falter/reverse in the 2010s. In 2017 the life expectancy for a man in England was 79.6 years, and for a woman 83.2 years. Yet, many would experience on average their last 16 and 19 years respectively living in poor health.[107] The figures for Scotland were worse, as was the fall in life expectancy observed between 2018 and 2020 (a loss of 2.5 months, compared to 1.8 months for England, 0.2 months for Wales, but a gain of 2.6 months for Northern Ireland).[108] These trends rang alarm bells of an underlying societal and economic malaise. If the variations in national life expectancy changes appeared relatively minor, measured in months, the variations in life expectancy within local areas remained shocking, especially when articulated through well-known spatial systems. Life expectancy dropped by twelve years over the course of a twenty-minute tube journey between Lancaster Gate in Central London, and Mile End, when mapped in 2012.[109] Women's health, and that of Black, Asian, and minority ethnic groups', continued to lag behind the relative improvements seen for men through this 'lost decade'.[110]

107 Public Health England (2018), 'Chapter 1: population changes and trends in life expectancy', *Health Profile for England: 2018.*

108 Whitty, C. and Rea, M. (2021), 'Life expectancy for local areas of the UK: between 2001 to 2003 and 2018 to 2020. Subnational trends in the average number of years people will live beyond their current age measured by "period life expectancy"', Office for National Statistics, Release date: 23/09/2021.

109 Dangerfield, A. (2012), 'Tube map used to plot Londoners' life expectancy', *BBC News London* [accessed 27/10/2023].

110 Marmot, M., Allen, J., Boyce, T., Goldblatt, P. and Morrison, J. (2020), *Health Equity in England: The Marmot Review 10 Years On*, Institute of Health Equity.

In 2018, when the annual NHS budget reached £152.9 billion (7.1% of GDP), the government signalled it was ready to address probably the largest efficiency challenge by creating the Department of Health and Social Care. Stimulated by predictions of a £2.5bn funding gap in social care in 2019-20, discussions focused on the possibilities for integrating budgets, despite the conflicting funding principles that healthcare was (almost) free at the point of delivery, but social care was means-tested, with individuals required to pay if their income or savings exceeded relatively low thresholds. With increasing numbers of older people living for longer with conditions such as dementia (for which care was not routinely covered by the NHS), many families had to make difficult care choices. Local authorities scaled back their provision of social care and private providers, especially those operating chains of care homes, increasingly profited from the large capital assets held by the over-65 generation. Although a cap on care home fees of £86,000 p.a. was proposed (and still awaits implementation), this did not include the 'hotel' costs charged by private care homes, which in some cases comprised 70% of the total cost.

4.6 COVID-19

The long-running concerns about efficiency and effectiveness of the NHS, and how it interfaced with social care and public health, were thrown into sharp relief by the arrival of the SARS-Cov-2 virus in the UK in early 2020. Its swift establishment as the disease 'COVID' challenged the global scientific community to rapidly understand transmission pathways, rates of reproduction and effective treatments, while in parallel searching for an effective vaccine. The pandemic exposed diverse risks: not only of maintaining daily life but also of allowing state welfare systems to be depleted to 'skeleton' levels. It soon became evident that COVID-19 had a disproportionate impact on Black, Asian, and minority ethnic communities: men of black African backgrounds had a mortality rate 2.7 times that of men of white ethnic backgrounds. For women of black African backgrounds their mortality rate was 2.0 times that of women from white ethnic backgrounds. Associations were made with rates of poverty and associated factors such as high-density housing, but there were also concerns about how Black, Asian, and minority ethnic patients and staff were treated within the NHS.[111]

The UK government's initial response was slow to coalesce, despite long-standing plans for emergency preparedness, resilience, and response. There had been relatively minor epidemics of influenza and SARS, another coronavirus, in the 2000s and 2010s, and PHE had inherited a suite of planning exercises from its predecessor the Health Protection Agency in 2003. The government stood up the statutory Scientific Advisory Group for Emergencies (SAGE) system, and the public information strategy relied heavily on the mantra of 'we are following the science', although they were not, with a visual reinforcement each day when Prime Minister Boris Johnson appeared at Downing Street press conferences flanked by Chris Whitty, the Chief Medical Officer for England, and Patrick Vallance, then Chief Scientific Advisor. The attempt to maintain a UK-wide approach broke down when some of the devolved nations imposed stricter measures, and for longer, than those used in England. The measures put in place – from lockdowns to mask wearing - did not sit well with maintaining an ideological commitment to freedom and supporting the economy, but new innovations such as asymptomatic testing through lateral flow tests and vaccinations, helped open up society. These were underpinned by recent scientific developments, especially in genetics, allowing mutations in the virus to be identified and the vaccines modified quickly. By March 2022, the UK government appeared to have lost patience. The experts were stood down and the public informed that they could 'live with COVID'.

[111] Butler, P. (2020), 'Nearly half of BAME UK households are living in poverty', *The Guardian* [accessed 27/10/2023]; Aldridge, R.W., Lewer, D., Katikireddi, S.V., Mathur, R., Pathak, N., Burns, R., Fragaszy, E.B., Johnson, A.M., Devakumar, D., Abubaker, I. and Hayward, A. (2020), 'Black, Asian and Minority Ethnic groups in England are at increased risk of death from COVID-19: indirect standardisation of NHS mortality data [version 2; peer review; 3 approved]', *Wellcome Open Research*, 5(88).

The pressures put on the NHS by COVID-19 were intense. Staff suffered burnouts and, despite huge public support, morale dropped – evidenced through rising rates of staff vacancies and calls for industrial action. In the midst of the pandemic, the government announced changes to both NHS and public health structures. The transition from CCGs to 42 Integrated Care Systems (ICSs) of varying sizes, flagged in the 2019 NHS Long Term Plan, were established in July 2022 through the Health and Care Act, but without a full merger of NHS and social care budgets. PHE was made the scapegoat for the shortcomings of the COVID-19 response, abolished, and replaced with the UK Health Security Agency (UKHSA) and the Office for Health Improvement and Disparities (OHID). The government's long-promised health disparities white paper was officially scrapped in January 2023, to be replaced by a 'major conditions strategy'.

4.7 Conclusion

This period, from 1974, witnessed over 40 significant reforms to the NHS and associated systems. Yet, the organisational learning between them appears non-existent. Who knows what has worked? Some initiatives had clear impact on health inequalities, such as Sure Start; others were damp squibs, such as Health Action Zones. Recurrent failures have been made, including over-ambitious plans with no pilot and evaluation phases, lack of engagement with the public and healthcare professions, lack of thought for resource planning, especially for workforces, and lack of tailoring to local needs. The political cycle has driven much of this change, and the associated demand for an early 'return on investment'. The governance of policymaking has responded – via new sources of expertise solicited from increasingly powerful organisations outside of Whitehall.

Yet, NHS output has increased in response to greater budgets, with more patient appointments, more treatments, more prescriptions – clear signs of increasing ill-health, especially in communities with poorer and/or older populations, and of the ability to make more expensive medical interventions. Multimorbidity – living with more than one chronic health condition – is now commonplace, and around a tenth of the population are living with four or more illnesses.[112] The NHS has retained its position as one of the most efficient and effective healthcare systems globally, but within it, a larger share of the service is now provided by private contractors, some of whom are UK outposts of large multinational companies such as Virgin, Circle, and United Health. Private Finance Initiatives (PFIs) which were developed in the 1990s to cope with the crumbling infrastructure of many hospitals, have proved huge drains on budgets, limiting the NHS's ability to address the backlog of repairs estimated at £10 billion in 2022. The most visible sign of a healthcare system at breaking point are the waits – for A&E treatment, for GP appointments, for diagnostic tests and treatments. A record seven million people are waiting for care in England (data is not easily found for the devolved nations). Some of those who can afford it are taking the private route. Those who cannot, hope that the government will not use the current issues to justify an end to the 'National Health Service'. The political fixation on the cost of treating ill-health remains, and until that is addressed by interventions in the wider systems that enable people to live healthy lives, the NHS will remain on the critical list.

112 Kingston, A., Robinson, L., Booth, H., Knapp, M., Jagger, C. and MODEM Project (2018), 'Projections of multi-morbidity in the older population in England to 2035: estimates from the Population Ageing and Care Simulation (PACSim) model', *Age and Ageing*, 47(3), pp. 374-80.

Conclusion: legacies and lessons from past to present

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The history of health policy over the last 175 years is a story of the establishment of a series of legacies which have presented policymakers with a set of enduring challenges. In this Conclusion, we review these perennial difficulties, but also point to some of the ways in which these could be overcome. There are lessons here for contemporary policymakers, but the historical evidence suggests that without addressing deeper problems, there are no easy fixes.

5.1 Structural problems may require structural solutions that lie outside 'health' policy

The big problems facing today's policymakers with respect to improving population health may seem quite different to those encountered by their predecessors in 1848. Non-communicable diseases like cancer and heart disease, chronic conditions such as diabetes and arthritis, as well as the needs of an ageing population, undoubtedly pose different challenges to those of the mid-nineteenth century. Coping with widespread outbreaks of infectious disease, poor child and maternal health, and the dangers of hazardous workplaces required different solutions to those needed today, but the ways in which policymakers met these challenges offer useful insights.

As Tom Crook showed in his chapter, improvements in urban sanitation from the mid-nineteenth century onwards led to significantly better public health. New infrastructure was required, especially the sewerage network and the provision of clean drinking water, but so too were political support and the introduction of new structures of regulation and management. These were vital for driving up standards in other areas, such as housing and the removal of nuisances. The betterment of health was one of the objectives of such initiatives, but these were not solely 'health policy', but rather part of a broader project of environmental, and to some extent economic and social, reform.

Indeed, as can be seen across both Crook and Martin Gorsky's chapters, improvements in population health were only partly related to improvements in health services. Increases in life expectancy and the epidemiological transition from infectious to chronic disease took place before the establishment of universal health coverage under the National Health Service. The rise in life expectancy began in the 1870s. Measures which addressed the determinants of health, such as the environment, economic development, and education, were just as, if not more, important than the technicalities of health service expansion. The health service focus has consistently meant that other areas important for health such as housing or water supply, have been neglected.

There are a number of parallels here for contemporary policymakers. Measures which address environmental drivers of ill-health, such as low emission zones, sit awkwardly between health, transport, and environmental policy domains, but the Victorian example demonstrates that change is possible if the political will is there. Likewise, tougher regulation of contemporary public health 'nuisances', such as fast-food outlet density or minimum unit pricing for alcohol, may result in improved population health if such measures can be made politically and socially palatable. Policymakers may need to act counter to public opinion, or at least ahead of it. The introduction of the ban on smoking in public places is a good, albeit complex, example here. A range of actors (including commercial interests) worked together to achieve change which some politicians feared would be unpopular, although public opinion shifted in favour of the ban over time. Infrastructural development is also likely to be necessary, not in the form of better sanitation (although the crumbling Victorian network undoubtedly needs an upgrade) but in greener, better-quality housing and in more effective digitisation of health services, systems, and information. Putting such measures in place will require popular as well as political support, at the local and national level. This may be hard to achieve at a time when faith in democratic institutions and 'elites' is low, but there are mechanisms and approaches (such as citizens' juries) that may be used to gain public trust.

5.2 Health policy is more than NHS policy, and ongoing issues can only be addressed by taking a more holistic view of health policy

Since its establishment in 1948, the NHS has come to dominate the health policy field. This is understandable, given the importance of health services for individual and collective health, to say nothing of the NHS's increasing economic, political, and cultural salience. But despite Bevan's aim for the NHS to be 'comprehensive' it never was (or perhaps ever could be). The elements that were left out of the original structure of the NHS such as social care, public health, and democratic representation, have presented policymakers with some of the longest running headaches. Looking at each of these in turn provides insight into pitfalls that could be avoided by taking a wider view.

By placing social care in local government, rather than the NHS, Bevan set up an artificial and often unworkable divide between the treatment of the acutely ill and the long-term needs of largely elderly patients. Facilities for social care, as Andrew Seaton noted in his chapter, were under-resourced compared to NHS facilities, leading to poor standards that were only partly addressed through de-institutionalisation. The dislocation between health and social care also presented enduring difficulties, which, as Sally Sheard shows in her chapter, successive governments have failed to grapple with. Although more recent changes, such as the establishment of the Department of Health and Social Care in 2018, have nominally brought health and social care policy closer together, the COVID-19 pandemic demonstrated that they are still too far apart. One frequently mooted suggestion to resolve this divide is to bring social care within the NHS. But without addressing some of the other aspects of Bevan's legacy, most obviously around resourcing health services, this may not provide the solution that many hope for.

Further evidence for the fact that incorporation within the NHS is not necessarily a panacea is provided by the fate of public health services and public health policy. In the early NHS, between 1948 and 1974, public health services were located within local government under the control of the Medical Officer of Health. As Seaton points out, public health officials often struggled to find a role within the new system and work with a health service that was primarily devoted towards hospital services for the acutely ill. Some of these difficulties were supposed to be resolved by the reorganisation of the NHS in 1973/74, which brought public health inside the service. But, as Sheard demonstrates, issues persisted. To a great extent, the NHS remained primarily a sickness service, with not enough emphasis on disease prevention, or on addressing the social, economic, environmental, and commercial determinants of health. The removal of public health services from the NHS and their return to local government in 2013 did nothing to ease such difficulties and may well have made them worse. Issues with coordination

and under-resourcing reappeared, if indeed they ever went away. However, the role of local government public health during the COVID-19 pandemic showed what an effective local government based public health could deliver. As Tom Crook comments, preventive public health had more coherence historically when based locally, but this was crowded out by the NHS. History would suggest that where services sit (inside or outside the NHS) is less important for effective operation and policy development than sufficient resources, coordination, and a recognition that service provision is only part of a larger endeavour. The Ministry of Health included responsibility for housing and for local government up to the 1950s, an early recognition of the relationship between health issues and the broader context in which these are located.

Another problem that Bevan left us with surrounds democratic representation, or rather lack thereof. Many pre-NHS health services, as Gorsky notes, contained mechanisms for democratic control through contributory member participation schemes. This was swept away with the coming of the NHS, and there was no equivalent in the early health service. Patient power within the NHS was very limited, something which was only partly rectified by the introduction of mechanisms such as the Community Health Councils in 1974, and the establishment of other tools to protect patient's rights like the Ombudsman and patient's charters. Much of this was focused on patients as individual 'consumers', and whether this equated to more democratic control of the NHS is highly debatable. Yet, offering the public greater say over health services and health policy is increasingly vital. Public support for difficult choices, whether at the micro level over which hospitals to close, or at the macro level around the proportion of public funds to spend on health services, is necessary, especially when resources are constrained.

5.3 The centralisation of health policy has advantages and disadvantages, but is most effective when core and periphery work together towards shared objectives

The story of British health policymaking up to and including the creation of the NHS is, to a great extent, one of increasing centralisation. As both Crook and Gorsky show, before 1948, health policy was often made at the local and regional level. Problems with service and health outcome variation, under resourcing, and poor coordination, together with a growing welfare state, helped drive forward the centralisation of health services and health policy. A centralised national health service certainly provided a number of advantages when it came to making health policy, but these could act as disadvantages too.

The centralised nature of the NHS and its funding from general taxation allowed policymakers to deal with issues around the cost of services in a coordinated way. Calculating costs, comparing Britain's record on spending to other nations, and looking at alternative ways to pay for health services became a feature of health policy making as the NHS matured. Health became directly political in a manner that is quite different to countries with other funding systems. Political control of the health service enabled successive governments to decide how much resource to put into services, but also how to shape and structure them. Up until the mid-1970s, the NHS remained largely unaltered from its original design, but as Sheard notes, since then the service has undergone a process of almost continual reorganisation and reform. This may have resulted in improvements of services and outcomes for some, but the constant churn makes it difficult to tell. Centralised political control provides an opportunity for change but rarely allows for time to see if this has worked. Delivery outside the political cycle is difficult as politicians always have half an eye on future elections and how issues may play with voters.

At the same time, while British health policymaking appears to have become more centralised, localism beneath the surface remained important. Indeed, the persistence of the NHS as a policy object should not obscure other kinds of de-centralisation. One of these is the proliferation of policy actors, especially over the last 40 years. Health economists and management consultants, to name but two, have come to play an increasingly important role in shaping health policy and practice. Another decentralising trend which was always present

in the NHS, but has come to the fore even more so recently, is devolution and regional variation. It was probably always true that there was no 'national' health service, but a series of health services that differed quite significantly between England, Wales, Scotland, and Northern Ireland, but this has become even more the case as national devolution gathers pace. Regional experiments in devolution, like 'Devo Manc', may push this even further. The nineteenth century examples such as the work of Chamberlain in Birmingham could also be drawn on here.

What can a contemporary policymaker take from this complex picture? Perhaps they would do well to emulate the Victorian reformers who managed to achieve change by getting central and local actors to work together. Coordination has long been a challenge, and the centralised nature of the NHS should not obscure the need to maintain a dynamic relationship between the core and periphery.

5.4 Conclusion

Making health policy is a messy business, and even more so when considered over a broad sweep of time. If one single 'lesson' can be extracted it is this: to truly achieve improvements in population health, policymakers should focus not solely on the NHS, but on the wider determinants of health. As research for decades has shown, social factors such as access to good food and quality housing, the attainment of secure employment and decent pay, alongside reducing pollution and stress, all improve health outcomes. Concentrating purely on service delivery, costs, and endless reorganisation has crowded out this bigger picture. To achieve change, it may require a re-orientation of health policy towards *public* health policy. It will also necessitate the boundaries of 'health' policy to be softened, as policymakers will need to work with other branches of government, and other sectors too.

History offers some examples of moments when significant change in health policy was achieved. Periods of crisis, especially those which went beyond just the health sphere, could prompt new developments. The ongoing reduction in alcohol consumption following wartime restrictions during World War One is one such case. So too is the introduction of the NHS after World War Two. Global conflict was not the only spur towards action. As previous work by the British Academy has suggested, the COVID-19 pandemic, whilst devastating, does present an opportunity for re-designing policy in a large range of domains that moves 'health' beyond its silo.[113]

Achieving change in health policy need not only be as a response to crisis. A broader, bolder vision for health is necessary. So too is public support, even if this may need to be won rather than taken for granted. History may not repeat itself, but it can provide a useful guide for policymakers looking to the future.

[113] The British Academy (2021), *Shaping the COVID Decade: Addressing the long-term societal impacts of COVID-19*; The British Academy (2021), *The COVID Decade: Understanding the long-term societal impacts of COVID-19*.

Chronology: a timeline of British health policy

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1846-1855: Nuisances Removal and Disease Prevention Acts (1846, 1848, 1849, and 1855)

Between 1846 and 1855, four statutes were passed which granted local authorities extra powers to deal with 'nuisances', a capacious category that applied to any insanitary conditions that threatened health. They were partly driven by the need to combat the cholera epidemics of 1848-9 and 1853-4. The 1855 Act consolidated and clarified earlier statutes and expanded the definition of a 'nuisance'.

1848: Public Health Act, 1848

The Public Health Act of 1848 established the General Board of Health, which was responsible for advising local authorities on public health matters such as epidemics and disease prevention. It was also empowered to establish and advise local boards of health in non-incorporated towns and health committees of towns and cities incorporated under the 1835 Municipal Corporations Act. The General Board of Health, however, could only compel the establishment of boards or committees under carefully specified circumstances (i.e. where the general death rate exceeded 23 per 1,000) and this power did not apply to London or Scotland.

Once established, boards and committees became responsible for removing 'nuisances', such as refuse and bad paving, and for implementing drainage, sewerage, and water-supply systems. They were also empowered to appoint inspectors of nuisances (later known as sanitary inspectors) and Medical Officers of Health (MOHs).

1851: Common Lodging Houses Act

This Act granted local authorities the power to inspect common lodging houses which were essentially cheap hotels and provided accommodation for itinerant workers and the very poor. They were also known as 'low lodging houses', and later 'dosshouses', and were regarded as hotspots of moral and physical ills.

1853: Vaccination Act, 1853

The Vaccination Act of 1853 made it compulsory for all children born after 1 August 1853 to be vaccinated against smallpox during their first 3 months of life. Parents who did not vaccinate their child could be fined.

1855: Metropolis Management Act, 1855

The 1855 Metropolis Management Act created the indirectly elected Metropolitan Board of Works (MBW). It replaced the Metropolitan Commission of Sewers, earlier established in 1848, as the body responsible for reforming London's sanitation. The main achievement of the MBW was the building of London's Main Drainage Scheme under the direction of its Chief Engineer, Joseph Bazalgette, between 1859 and 1875. It was also responsible for building new main thoroughfares, bridges across the Thames, and new parks and open spaces. It was replaced in 1889 by the London County Council.

1855: Nuisances Removal and Diseases Prevention Acts consolidation and amendment

This Act consolidated and amended the Nuisances Removal and Diseases Prevention Acts of 1848 and 1849. It required local authorities to employ sanitary inspectors and gave local authorities powers to enter properties containing 'nuisances'.

1858: Public Health Act, 1858

The Public Health Act of 1858 replaced the Public Health Act of 1848 and abolished the General Board of Health. The Secretary of State for the Home Department and the Local Government Act Office took on responsibility for managing local boards of health, while a new Medical Department of the Privy Council assumed responsibility for vaccination and responding to outbreak of infectious disease.

1858: 'Model' buildings byelaws

The 1840s saw improvement in housing standards under the auspices of philanthropic societies and paternalist employers. In 1858, the Local Government Act Office issued the first set of model building byelaws to guide local authorities when formulating their own.

1864: The Contagious Diseases Act, 1864

The Contagious Diseases Act was designed to prevent venereal disease in the Armed forces. It focused on regulating 'common prostitutes', and made it the law for women suspected of prostitution to register with the police and submit to an invasive medical examination and if found to be infected a woman could be confined to a 'lock hospital'. It was extended in 1866 and 1869 but it was repealed in 1886 after protests at the unfair treatment of women.

1866: Sanitary Act, 1866

The Sanitary Act 1866 made it compulsory for local authorities to improve sanitary conditions and remove nuisances to public health. Overcrowding in residences was made a notifiable nuisance and local authorities became formally responsible for ensuring adequate sewerage systems were in place.

1869-1871: Royal Sanitary Commission

By the 1860s frustration was mounting among medical professionals and sanitary reformers that the administration of public health still lacked a clear, systematic institutional framework. In 1868 the National Association for the Promotion of Social Science and the British Medical Association formed a Joint Committee to lobby for a royal commission to examine the administration of public health as a whole—and one was quickly granted: the Royal Sanitary Commission, as it became known. The evidence the Commission received and the recommendations it put forward directly informed the major statutory interventions of the period 1871–75.

1871: Local Government Board Act, 1871

The Local Government Board Act created the Local Government Board (LGB). The aim of the LGB was to provide for the consolidated management of administration of the poor law and the public health work of the Local Government Act Office and the Medical Department of the Privy Council. The LGB became the principal central authority relating to health policy for over forty years and was represented in parliament and Cabinet by a 'president'. It was replaced in 1919 by the Ministry of Health.

1872: Public Health Act, 1872

The Public Health Act of 1872 established sanitary authorities in both urban areas and rural areas and made compulsory the appointment of both Medical Officers of Health (MOHs) and sanitary inspectors.

1875: Artisans' and Labourers' Dwellings Improvement Act, 1875

This Act empowered local authorities to purchase and demolish slum houses and rehouse those who had been displaced. Further acts in 1885 and 1890 – the Housing of the Working Classes Act 1885, and the Housing of the Working Classes Act 1890 – expanded these powers and formalised the ability of local authorities to provide housing of their own.

1875: Public Health Act, 1875

This Act was a major piece of statutory consolidation, bringing together and clarifying the many pieces of legislation that had arisen since the 1840s. It reaffirmed that named local authorities were to act as rural and urban sanitary authorities, granting them jurisdiction over the urban and rural sanitary districts created in 1872. It further specified their statutory obligations to provide clean water, dispose of sewage and refuse, ensure that only safe food was sold, regulate nuisances, and prevent and manage outbreaks of infectious disease. It provided the principal source of statutory guidance through to the interwar period.

1876: Rivers Pollution Act, 1876

This Act prohibited the discharge of polluting matter into rivers by industrial works. It applied only to new works, however, and allowed exemptions for existing firms where they could demonstrate that they had explored the 'best practicable and available means' of avoiding pollution.

1880: Employers' Liability Act, 1880

This Act modified the legal barriers to successful negligence suits by employees against their employers, facilitating a growth in the number of personal injury actions by workers.

1883: Factory Act, 1883

This Act controlled the production of white lead, a product vital to the paint trade. It was also the first Act to target a specific occupational disease. Further Acts followed in 1895 requiring the reporting of cases of anthrax, arsenic, and lead poisoning, and in 1908 banning the manufacture of white phosphorus matches.

1889: Infectious Disease Notification Act, 1889

The Act provided for the compulsory notification of infectious diseases in London and empowered other local authorities to do the same. A further Act in 1899 made notification a compulsory responsibility for all local authorities.

1897: Workmen's Compensation Act, 1897

This Act enabled employees to obtain financial compensation for injuries sustained in the workplace, even when it was not possible to prove negligence on the part of their employers. The Act was initially limited to accidents, but a further Act in 1906 allowed claims from employees suffering from one of six specified occupational diseases, including anthrax and arsenic poisoning.

1902: Midwives Act

This Act required midwives to be trained and registered in order to reduce maternal and infant mortality. The later Midwives Act, 1916, enforced registration and training and made it more rigorous, and the Midwives Act, 1936, made it an offence for an untrained midwife or nurse to attend a delivery.

1903: The Interdepartmental Committee on Physical Deterioration

The Interdepartmental Committee on Physical Deterioration attempted to understand the causes of the nation's poor health. It highlighted the link between lack of nutrition and poor health, and the committee estimated that a third of children were malnourished.

1905-9: Royal Commission on the Poor Laws and Relief of Distress

Formed in 1905 under a Conservative government, the 1905-9 Royal Commission on the Poor Laws and Relief of Distress was the product of a growing consensus—partly prompted by fresh perspectives on the nature of poverty and unemployment—that the entire system of poor relief initially founded in 1834 required re-examining. The Commission eventually led to the production of two highly critical but conflicting reports—a Majority Report and a Minority Report—and both were largely ignored by the then Liberal administration, which pressed ahead instead with the introduction of a new national insurance system.

1906: Education (Provision of Meals) Act, 1906

The Act gave local authorities the power to provide free school meals for poor children.

1907: Education (Administrative Provision) Act, 1907

The Act required local authorities to carry out medical examinations and provide relevant treatment for school children.

1911: National Insurance Act, 1911

The National Insurance Act of 1911 created a national system of social insurance to protect working people against the loss of income resulting from sickness or unemployment, thereby reducing demand on the poor law while enhancing access to welfare protection among the population at large. The Act was split into two parts: health insurance and unemployment insurance. It was funded by contributions from workers, employers and the State. The health insurance component provided for the receipt of sickness benefit payments for a specified period, as well as a range of other benefits, including medical treatment and assistance from approved doctors.

1918: Maternity and Child Welfare Act

This Act provided a central government subsidy towards (not the full cost off) local authority provision of hospital services for children under five, maternity hospitals, home helps for mothers after childbirth, local maternal and child health and welfare clinics and other services, though none were obligatory.

1919: Ministry of Health Act, 1919

The Ministry of Health Act of 1919 established the Ministry of Health, which henceforth became the key government department responsible for health policy. It encompassed the functions of the Local Government Board and national health insurance administration, as well as local authority and health-related duties, such as midwifery.

1920: Interim Report on the Future Provision of Medical and Allied Services (Lord Dawson)

Sir Bertrand Dawson was commissioned in 1919 by the new Ministry of Health to chair a council to advise on the systematised provision of health services. He reported in 1920 outlining a plan to bring together existing services funded by national health insurance, local authorities, and voluntary bodies in a coherent and comprehensive healthcare system. The plan was never published.

1920: Dangerous Drugs Act, 1920

The Dangerous Drug Act of 1920 Incorporated the provisions made under the Defence of the Realm Act regulations. It prohibited the possession and unlicensed import or export of opium, heroin, and cocaine. It also established that medical practitioners were allowed to prescribe morphine, cocaine, and heroin.

1921: Inquiry into voluntary hospital finances (Lord Cave)

Lord Cave was appointed to lead an inquiry into the financial state of voluntary hospitals and to make recommendations on ways to help those in trouble.

1921: Public Health (Tuberculosis) Act, 1921

Country and county borough councils were made responsible for the provision of sanatoria, care, and aftercare services for TB patients.

1921: Birth control clinic founded in London

Free and open to all married women, the 'Mothers' Clinic for Constructive Birth Control' was founded in Holloway, by Marie Stopes. It was later moved to Camden.

1928: Dangerous Drugs Act, 1928

The Dangerous Drugs Act of 1928 criminalised possession of cannabis. Doctors continued to be able to prescribe any drugs as treatments, including for addiction.

1929: Local Government Act, 1929

The Act consolidated local government structures. It also sought to reform the administration of poor relief by transferring the responsibility to care for the poor to local authority public assistance committees (PACs). Poor relief was renamed 'public assistance'.

1930: Mental Treatment Act, 1930

This Act replaced the term 'lunatic' and 'asylum' with 'patient' and 'hospital' and empowered local authorities to fund out-patient and aftercare facilities.

1930: Formal birth control services for married women initiated

The Ministry of Health permitted local health authorities (LHAs) to provide birth control advice for married women through voluntary organisations under circumstances where a further pregnancy would be detrimental to the health of the woman.

1934: The Milk Act, 1934

The Milk in Schools Scheme (MISS) expanded across the UK.

1935: British Hospitals Association Commission into collaboration in the voluntary hospital sector

The British Hospitals Association set up a commission to review the voluntary hospital sector which was facing financial difficulties. The commission recommended the creation of 13 regional hospital councils and the setting up a regional fund for when a hospital in deficit could benefit from the surplus generated by another. However, there were no funds to implement its recommendations.

1935: Air Raid Precautions (ARP)

Department to supervise civil defence measures which became responsible for the planning and organisation of a national hospital service, which could deal with air raid casualties.

1936: Public Health Act, 1936

This was introduced to replace all previous regulation relating to public health matters, including disease control, prevention, and nuisance removals and inspections.

1937: Commission into collaboration in the voluntary hospital sector (Lord Sankey)

The British Hospital Association set up a commission in 1935, chaired by Lord Sankey, to review the possibility of greater collaboration within the voluntary hospital sector. It reported in 1937 recommending the creation of 13 regional hospital councils, which would coordinate the work of all hospitals in a given area. Whilst the report was well received there were not enough funds for implementation.

1938: Ministry of Health responsible for the organisation of a national hospital service for civilian casualties following an air attack

The Ministry of Health took responsibility for first aid posts and ambulance service.

1939: Emergency Hospital Service

The potential for civilian casualties led the development of an emergency hospital service whereby central government took the right of direction over voluntary and municipal hospitals.

1942: Social Insurance and Allied Services (Beveridge Report)

The Inter-Departmental Committee, led by Sir William Beveridge, reviewed the functioning of the social insurance schemes and set out recommendations on how to merge them. The final report, known as the Beveridge Report, highlighted the detrimental effects of the 'Five Great Evils' plaguing society: want, disease; ignorance; squalor; and idleness. The report created a compulsory social insurance scheme, which would provide a degree of non-means tested benefit in return for contributions.

1944: National Old People's Welfare Committee

The committee attempted to improve the welfare of poor people after the inadequacies of the Poor Law, especially the older age groups. It incorporated a number of organisations working at a local level, to improve older people's welfare.

1944: National Health Service White Paper

The White paper set out the concept for a comprehensive, free, and unified health service, reflecting the government's belief that healthcare should be made available to all, through a publicly organised service.

1944: Education Act, 1944

Made the provision of milk and school meals a statutory duty for local authorities.

1946: The National Insurance Act, 1946

The National Insurance Act extended the range of the National Insurance Act of 1911 to require everyone of a working age (except for married women) to pay a weekly contribution. Benefits available included sickness benefit, widow's benefit, and unemployment benefit. Pensions would be paid to women at 60 and men at 65.

1946: National Health Service Act, 1946

The Act provided for the establishment of a comprehensive health service for England and Wales, that was free at the point of use and universally available to all. Public Health remained the responsibility of local councils.

1948: The National Assistance Act

The Act aimed to ensure that assistance was given to people, over the age of 16, who were not making National Insurance contributions and were 'without resource'. The Act made it compulsory for residential care homes for the disabled and elderly to be registered. Local authorities were required to provide accommodation for the elderly, frail and infirm who required support.

1950: Public Health in 1948: remarkable statistics: the first months of the National Health Service

Report by the Ministry of Health examining health and mortality outcomes between the start of the NHS on 5 July 1948 and March 1949. It indicated a mortality decline of 20%.

1950: Doll and Bradford Hill report on smoking and carcinoma of the lung published

Richard Doll and Tony Bradford Hill's paper on smoking and carcinoma of the lung stated that smoking was an important cause of lung cancer.

Doll, R. Bradford Hill, A. (1950), 'Smoking and carcinoma of the lung: preliminary report', *British Medical Journal,* 2:739.

1952: Implementation of prescription fees

Prescription charges were first introduced in 1952 with limited exemptions. They were abolished in 1965 but reintroduced, with further exemptions, in 1968 due to budgetary pressures.

1953: The Guillebaud Committee established

Commissioned by the Conservative government to investigate the cost of the NHS. It was chaired by a Cambridge economist Claude Guillebaud. Based largely on the work of economists Brian Abel-Smith and Richard Titmuss (published in March 1956 as *The cost of the National Health Service in England and Wales*). The report was published in 1956.

1956: The Guillebaud Report published

The committee revealed that, in relative terms, the cost of the NHS was decreasing and was underfunded, and suggested that future increases would be met through economic growth. Alternative models for the NHS were considered but it concluded that it was premature for any radical restructure, though it remained critical of the tripartite structure of the service.

1956: Clean Air Act, 1956

After the Great Smog of 1952 the Act aimed to tackle the smog and air pollution created by the burning of coal and industrial activities.

1957: The Percy Commission

Royal Commission on the Law Relating to Mental Illness and Mental Deficiency chaired by Baron Percy of Newcastle. It recommended that care should be provided in the community.

1959: The Mental Health Act, 1959

The Mental Health Act of 1959 implemented the legislative framework to implement the Percy Commission's recommendations from 1957. The Act removed the distinction between psychiatric and other hospitals, ensuring that 'mentally ill' patients could benefit from general health and social service facilities, as well as encouraging equality between mental and physical health.

1961: Establishment of the National Air Pollution Monitoring Network

Called the National Survey, it was established to monitor black smoke and sulphur dioxide at around 1200 sites.

1961: Enoch Powell's 'water tower' speech

Minister of Health, Enoch Powell, in a speech to the Annual Conference of the National Association for Mental Health, outlined his desire to see greater community care provision for mental health patients.

1961: The Pill becomes available on the NHS

Health Minister Enoch Powell announced that women who wished to have oral contraception would be able to receive it through the NHS. The Family Planning Association (FPA) approved the use of oral contraceptives in its clinics.

1962: A hospital plan for England and Wales

The Conservative Minister of Health Enoch Powell's plan to develop a programme of hospital building until the 1970/71 financial year. It established the size and types of hospitals needed, together with GP and domiciliary services and aimed to initiate rebuilding of hospitals. It promised ninety hospitals in England and Wales. The OPEC oil crisis in 1973 meant some hospital projects were abandoned altogether.

1964: Water fluoridation scheme

Following a pilot scheme commenced in Birmingham in 1964 to help prevent dental carries (tooth decay). Further schemes were progressively introduced across the country.

1965: First seatbelt legislation

All new cars sold in Europe were required to have seat belt anchorage points for the front They were not compulsory to be worn until 1983 in the UK and for rear passenger in 1991.

1966: The Ministry of Social Security Act, 1966

This Act created the Ministry of Social Security and the post of Minister of Social Security, and merged the Ministry of Pensions and National Assistance with the Supplementary Benefits Commission.

1967: NHS (Family Planning) Act

The Act enabled local health authority-funded family health clinics to give contraceptive advice to unmarried women, on both medical and social grounds.

1967: Abortion Act

The private member's bill brought by David Steel MP legalised abortion under certain conditions and required approval from two doctors.

1967: Road Safety Act, 1967

The Act made it an offence to drive a vehicle with a blood alcohol concentration of over 80mg of alcohol per 100ml of blood. In addition, all cars sold had to be fitted with front seatbelts and cars manufactured since 1965 had to be retrofitted with front seat belts.

1968: Clean Air Act, 1968

In the wake of the Great Smog of 1952 this legislation aimed to improve air quality which suffered due to smog and air pollution from coal and industrial activities. The Act gave local authorities the power to control emissions of smoke, grit, dust, and fumes from industrial premises and furnaces, and set up smoke control zones in which emissions from these materials could be banned.

1968: National Health Service: the administrative structure of the medical and related services in England and Wales, green paper

The paper focused on administrative reform of the NHS. The paper stated that it was important for central government to set the strategic direction for the health system and allocate resources, but its role in direct management should be limited. It proposed the creation of up to 50 authorities in local areas (to be known as area authorities), which would be directly responsible to the minister of health.

1968: The Seebohm report

Lord Frederic Seebohm was appointed to review the organisation and responsibilities of the social services functions of local authorities. The report recommended the amalgamation of several functions to form a single social services department.

1968: The Health Services and Public Health Act, 1968

Section 45 of the Act empowered local authorities to make arrangements to promote the welfare of old people. They were able to employ voluntary organisations to discharge this function on their behalf.

1968: Inquiry into Ely Hospital

The report recommended that the system for investigating complaints should be reviewed, and that the establishment of an independent inspectorate should be considered.

1969: The Bonham-Carter report

Reviewed the role of district general hospitals in the NHS.

1970: The Chronically Sick and Disabled Persons Act, 1970

The Act required local authorities to provide welfare services to disabled people who fell within section 29 of the National Assistance Act 1948 (those who were blind, deaf, people with learning disabilities or mental illness, and disabled people).

1970: The future structure of the National Health Service in England, green paper

Secretary of State for Social Services, Richard Crossman's paper concluded that Area Health Authorities would run the NHS, reporting directly to the secretary of state; that administrative boundaries between the NHS and local authorities providing public health and personal social services must be clear; and that the number of new health authorities must match the number of local authorities (the new counties and county boroughs).The paper was criticised for increasing centralised control of the NHS.

1970: The Local Authority Social Services Act, 1970

The Act created a framework for social services and a single social services department in every local authority.

1971: Better services for the mentally handicapped, white paper

Reflected a desire to move away from caring for people with a 'mental handicap' in institutional settings and to increase the provision of local and community care.

1971: Attendance Allowance introduced

The Attendance Allowance was to act as a non-means-tested benefit for people required personal assistance for a serious or debilitating illness or disability.

1972: National Health Service reorganisation, white paper

This white paper detailed major structural and administrative reform of the health system.

1972: Faculty of Public Health established

The Faculty of Public Health was established in 1972 as a registered charity in response to a recommendation made by the Royal Commission on Medical Education (1965–68).

1972: Management arrangements for the reorganised National Health Service report (Grey Report)

A group chaired by the then Permanent Secretary, Sir Phillip Rogers, published what became known as the 'Grey Report'. It introduced the idea of 'consensus management' and set out management roles and responsibilities.

1973: NHS Reorganisation Act, 1973

Utilising management consultancy to help shape the re-organisation, this Act, unified the different parts of the health service and brought responsibility for public health (which had previously been based in local government) within the NHS. It established principles of integration and managerialism and introduced the issue of patient rights with the development of Community Health Councils (CHCs).

1974: Resource Allocation Working Party (RAWP)

The Resource Allocation Working Party was established to try to lessen the differences in health spending between the North and South of England. The report established that going forward resources should be allocated according to measure of need.

1974: British Medical Association (BMA)

The BMA became the recognised trade union for doctors.

1975: The Social Security Act, 1975

The Act set out benefits and entitlements under the social security system and introduced the Invalid Care Allowance for carers.

1975: Better services for the mentally ill, white paper

The white paper emphasised the need to shift from an institutional model of care and improve community provision of services for people with mental illness.

1976: The Royal Commission on the National Health Service commissioned

The Labour party established a Royal Commission on the National Health Service, chaired by Sir Alec Merrison. Facing concern over NHS financing and beds for private patients in NHS hospitals it considered the best use and management of the financial and human resources in the NHS with a UK-wide focus. The Commission reported in 1979.

1976: DHSS Report *Prevention and Health, Everybody's Business* published

A discussion paper that outlined 'a reassessment of public and personal health' and argued that there should be a shift from a curative service to one that promoted health. It argued that the main killer diseases – coronary heart disease, lung cancer, and bronchitis – were largely caused by people's behaviour and that both individuals and government must accept responsibility for health.

1977: The National Health Service Act, 1977

Provisions which aimed to secure the separation of private and NHS facilities and the progressive withdrawal of accommodation and services at NHS hospitals for private patients. However, the provisions relating to pay beds were repealed by the Conservatives 3 years later in the Health Services Act 1980.

1977: The Working Group on Inequalities in Health (Sir Douglas Black) commissioned

The working group chaired by Sir Douglas Black was commissioned to investigate the variation in health outcomes across social classes and consider the causes and policy implications.

1979: Merrison Report

The Royal Commission on the National Health Service established in 1976 and chaired by Sir Alec Merrison reported in 1979 and recommended that the operational responsibility of the NHS should be placed with regional health authorities (RHAs). The Commission argued that there were too many administrative layers in the system and suggested that while regions should retain planning functions there should only be one tier below RHAs.

1979: Patients First consultation document

The document suggested changes to the structure and management of the NHS to improve responsiveness of the service.

1980: Health Services Act, 1980

Provided for structural reorganisation of the NHS in 1982. It established district health authorities (DHAs) and specified that regional areas did not need to be based around area health authorities.

1980: Inequalities in health: report of a research working group (also known as the 'Black Report')

The working group established by the Labour Government in 1977 and chaired by Douglas Black demonstrated that mortality rates varied across the social groups, with persons in lower social groups having higher rates of mortality. Inequalities in access to health services, such as preventative services, were also highlighted, noting low rates of uptake by the working classes.

1983: Mental Health Act, 1983

The Act enabled the state to detain and treat people with severe mental health problems.

1983: NHS Management Inquiry

Roy Griffiths, a Director of J Sainsbury plc, led an inquiry into the effective use and management of manpower and resources. Recommendations included a Health Services Supervisory Board, NHS management board, and appointment of general managers at all levels. It was seen as leading to the introduction of general management in the NHS.

1985: House of Commons Committee on Social Services report on community care

The House of Commons Committee on Social Services backed the concept of community care. However, concerns were raised over the release of 'mentally disabled' people into the community without sufficient support.

1985: Argument for internal market

Reflections on the management of the national health service by economist Alain Enthoven argued that the creation of an internal market within the NHS would offer benefits over NHS structures where referrals were not tied to payment.

1986: Disabled Persons Act, 1986

The Act sought to improve services for people with disabilities through representation and putting further responsibilities on local authorities.

1987: Automatic urban monitoring network

A network to monitor compliance with the emerging EC Directive limit on air quality value.

1987: AIDS: Don't Die of Ignorance

Public Health campaign: 'AIDS: Don't Die of Ignorance', to raise public awareness of HIV/AIDS. Leaflets were delivered to every home in the country and public information broadcasts were screened.

1987: Promoting better health, white paper

The white paper strengthened the role of primary care in health promotion and the prevention of ill health. Doctors' terms of service were amended to include health promotion.

1988: NHS breast screening programme

Department of Health initiated the NHS breast cancer screening programme.

1988: NHS cervical screening programme (NHSCSP)

Department of Health initiated the NHS cervical cancer screening programme.

1988: Public health in England: Report of the Committee of Inquiry into the Future Development of the Public Health Foundation

Committee of Inquiry into the Future Development of the Public Health Function, chaired by Sir Donald Acheson. It had the remit to consider the future development of the public health function, including the control of communicable diseases and the specialty of community medicine, following the introduction of general management into hospital and community health services, and recognising a continued need for improvements in effectiveness and efficiency; and to make recommendations as soon as possible.

1988: Caring for people: community care in the next decade and beyond, white paper

The white paper proposed transferring responsibility for the procurement of community care services to local government.

1989: Working for patients, white paper

The white paper proposed significant reforms and introduced a divide between those who provided care and those who purchased it, effectively creating an internal market in the NHS.

1990: GP contract incentives for health promotion

The new contract gave general practitioners more incentive to become more involved in health promotion.

1990: The National Health Service and Community Care Act, 1990

The Act made provisions to split the provision and commissioning of healthcare. It created NHS trusts and changed the way local authorities carried out their social care functions.

1990: The Health Select Committee (later the Health and Social Care Select Committee)

The Health Select Committee and the Social Security Select Committee were established, replacing the Social Services Select Committee.

1990: The Environmental Protection Act, 1990

The Environmental Protection Act covered waste management and the control of emissions into the environment.

1991: NHS trusts established

57 trusts assumed responsibility for the ownership and management of hospitals, which had been managed or provided by regional, district or special health authorities.

1991: Citizen's Charter

The Citizen's Charter was intended to reset the relationship between citizens and public services, emphasizing citizens as consumers.

1992: The Health of the Nation – a strategy for health in England, white paper

This white paper outlined a health policy framework for the following 5 years and included a strategic approach to population-wide health improvement.

1992: Private Finance Initiatives (PFI) schemes

In 1992, the Conservative government introduced private finance initiatives (PFI). The goal was to utilise the efficiency, management, and commercial expertise of the private sector. PFI was used where there was significant capital expenditure needed and ongoing service requirements such as for schools, hospitals, roads, and prisons.

1995: The Carers (Recognition of Services) Act, 1995

Carers received the right to request a needs assessment and capability to care for someone who was being assessed for community care services.

1995: Health Authorities Act, 1995

The Act resulted in regional NHS executive offices replacing Regional Health Authorities, District Health Authorities, and family health services authorities.

1996: UK National Screening Committee

The UK National Screening Committee was created to provide advice on population screening technologies and programmes.

1996: 'Opportunity and choice', white paper

The government set out proposals to give professionals working in primary care the opportunity to test various forms of contracting.

1997: Minister of Public Health

Following their Manifesto's pledge to improve public health the Labour Party appointed the first Minister of Public Health.

1997: The UK Air Quality Strategy (AQS)

The strategy set targets for benzene, 1,3-butadiene, CO (carbon monoxide), lead, NO2 (nitrogen dioxide), ozone, PM10 (Particulate Matter with particles with a diameter of less than 10µm), and SO2 (sulphur dioxide), to be achieved between 2003 and 2008.

1997: The NHS (Primary Care Act), 1997

The Act enabled piloting of different types of primary care contracting arrangements and established the means by which GPs could be directly employed.

1997: 'The new NHS: modern, dependable', white paper

The new Labour government set out its plans for NHS reform and programmes to improve public health.

1998: Political devolution of the UK's health services

Powers were transferred to the Scottish Parliament and Welsh Assembly on 1 July 1999, and to the Northern Ireland Assembly on 2 December 1999.

1998: 'Our healthier nation: a contract for health', green paper

The Government, in looking at the need to improve health and to narrow health inequalities, took the approach of a national contract between government, individuals, and communities. The intention was to deliver through the development of health improvement programmes (HIPs) by local health authorities.

1998: Sure Start programme

Sure Start was announced by Gordon Brown as a programme to increase support for children in their earlier years.

1998: The 'path of least resistance' report

Government-commissioned report on the rise of antimicrobial resistance.

1998: Report of the Independent Inquiry into Inequalities in Health (chaired by Sir Donald Acheson)

The report of the Independent Inquiry into Inequalities in Health made recommendations on health, environmental, and social factors including: health impact assessments for all policies that were likely to have a direct or indirect impact on health and health inequalities, and placing a partnership duty on the NHS executive and regional government to ensure local partnerships between health and local government.

1998: Caring about carers: a national strategy

This saw publication of the first national carers strategy with the intention to improve information, support and care available to carers.

1998: Public service agreements (PSAs)

The Labour government set new targets to reduce the time patients spent on NHS waiting lists and to reduce health inequalities. They were abolished in 2010.

1999: Establishment of National Institute for Clinical Excellence (NICE)

NICE was an arms-length body to review new treatments against cost effectiveness thresholds before approval for use in the NHS. It aimed to reduce variation of NHS services. NICE later became the National Institute for Health and Care Excellence and incorporated public health.

1999: Health Act, 1999

The Act was intended to improve local authority and NHS coordination, abolish GP fundholding and provided for Primary Care Trusts.

1999: Saving Lives: Our healthier nation, white paper

Government plan to reduce poor health. It utilised disease-based targets rather than the social determinants of health.

1999: Health Development Agency (HDA)

New statutory organisation to improve standards in public health.

1999: Food Standards Agency, 1999

The Food Standards Act 1999 established the Food Standards Agency (FSA) with the main objective to protect the public's health in relation to food.

2000: NHS Plan, 2000

The plan included significant health and care system reforms including setting targets for acute services; establishing closer relationships between the private sector and the NHS and responded to the 1999 Royal Commission's report on long-term care.

2000: Review of the Air Quality Standards (AQS)

This review led to the tightening of some existing targets and introduced new ones to protect vegetation and ecosystems. Targets for particulates were relaxed as it was thought that national measures alone would not achieve the 1997 PM10 targets.

2000: BSE outbreak: inquiry report

Inquiry into the BSE (bovine spongiform encephalopathy) in cattle and vCJD (Variant Creutzfeldt-Jakob Disease) outbreak in humans. It directed criticism at the government handling of the crisis.

2001: Health Select Committee report on public health

It had been feared that public health would 'fall between two stools'. In contrast the committee supported partnership working between the NHS and local government to minimise fragmentation between services and to avoid inefficient use of resources.

2001: Health and Social Care Act, 2001

The Act set out to cover legislation to underpin the proposals outlined in the NHS plan, including the formation of care trusts.

2001: 'Shifting the balance of power within the NHS', white paper

The white paper focused on the transfer of responsibilities to frontline staff and communities.

2002: Getting ahead of the curve – a strategy for combating infectious diseases

Department of Health strategy for reducing infectious diseases and a proposed new National Infection Control and Health Protection Agency.

2002: Strategic Health Authorities (SHAs)

SHAs and primary care trusts replaced regional offices, health authorities, and primary care groups with the intention of shifting power to the local level.

2002: National Care Standards Commission (NCSC)

The NCSC was created to oversee health and social care services and improve the quality of services.

2002: 'Securing our future health' review

Sir Derek Wanless led the review assessing long-term trends impacting the NHS and to quantify the resources necessary for it to remain comprehensive and available to all.

2002: 'Delivering the NHS Plan: next steps on investment, next steps on reform', report

The report reviewed progress since the NHS plan. It introduced 'payment by results' and proposed new regulatory bodies for health and social care.

2002: National Health Service Reform and Health Care Professions Act, 2002

The Act legislated for recommendations around the NHS structural framework following the Bristol inquiry and 'Shifting the balance of power within the NHS'.

2003: The Health Protection Agency (HPA)

The HPA was established as a special health authority to protect people against infectious diseases and prevent harm from industrial incidents.

2003: National minimum standards for care homes

Standards were set out for care homes for adults and older people for NCSC inspectors to use when inspecting care and private health providers.

2004: 'Securing good health for the whole population', report

Sir Derek Wanless reviewed cost-effective approaches to improving public health and reducing health inequalities.

2004: 'The NHS improvement plan: putting people at the heart of public services', white paper

The white paper outlined priorities for the NHS until 2008. It confirmed there would be continued investment in order to increase capacity across the system.

2004: 'Choosing health: making healthy choices easier', white paper

The white paper followed a public consultation which found that the public wished to make their own decisions when it came to their health, but that they required assistance.

2005: Shipman inquiry

Dame Janet Smith chaired an independent public inquiry into what had happened after GP Harold Shipman was convicted of murdering 15 of his patients.

2005: 'Independence, well-being and choice', green paper

The paper invited comments for changes to social care and a long-term vision to facilitate services to become 'person-centred, proactive, and seamless'.

2005: The Health and Social Care (Community Health and Standards) Act, 2005

The Act provided for the creation of NHS foundation trusts which had financial and management freedoms – and a new independent regulator.

2005: 'Choice, Responsiveness and Equity', consultation

Consultation to examine what patients and the public would want choice within the health service to look like.

2005: 'Commissioning a patient-led NHS', letter and response

Chief Executive of the NHS Sir Nigel Crisp set out the ways in which commissioning could be further developed and the House of Commons Health Committee assessed suggestions for restructuring Primary Care Trusts.

2005: 'Our health, our care, our say', white paper

Plan for improved prevention services, greater choice, improved access to community care, and more support for people with long-term health problems. Sir Derek Wanless's review looked at long-term trends in social care requirements for older people and the resources required to provide comprehensive care.

2006: Bowel Cancer Screening Programme (BCSP)

The BCSP automatically invited people aged between 60–69 (inclusive) and registered with a GP to use an at home screening kit.

2006: National Health Service Act, 2006

The National Health Service Act consolidated legislation related to the health service, encouraging further integration.

2006: 'The future regulation of health and adult social care in England'

The Department of Health launched 'The future regulation of health and adult social care in England'. This was a consultation on the way and means of integrating the regulation of NHS and adult social care services.

2007: Smoking ban in England

Smoking in enclosed public places was banned in England after studies in the 1950s, demonstrated the link between smoking and lung cancer which led to a series of campaigns to restrict smoking.

2007: Local Government and Public Involvement in Health Act, 2007

The Act placed responsibility on local authorities and primary care trusts to prepare a joint strategic needs assessment of health and social care needs.

2007: Mansell Report

The 'Services for people with learning disabilities and challenging behaviour or mental health needs' report provided good practice guidance for commissioners purchasing services.

2008: 'Healthy weight, healthy lives: a cross government strategy for England', document

The strategy document was intended to attack rising obesity levels and revealed that two-thirds of all adults and children were either overweight or obese.

2008: 'Independent Living' strategy

The Independent Living strategy was aimed at achieving government goals to improve the lives of disabled people by means of a 5-year cross-government programme.

2008: 'Any willing provider', commissioning

Patients were given the right to choose any NHS-funded provider following a referral for routine-elective hospital services.

2008: 'Carers at the heart of 21st century families and communities', strategy

The government strategy emphasized the importance of carers. Options included breaks, better provision of information and training and health checks.

2008: 'High quality care for all: NHS next stage review', final report

Lord Darzi's review reflected the government's plans to reform the NHS emphasising its preventive role in reducing ill health.

2008: Health and Social Care Act, 2008

The Act established the Care Quality Commission (CQC) as a new independent regulator for health and social care, taking over the roles of the three previous organisations.

2008: Human papilloma virus (HPV) vaccine

Introduced the HPV vaccination for females aged 12–13.

2009: 'Change4life', campaign

The 'Change4life' campaign was launched following on from recommendations in the 'Healthy weight, healthy lives' strategy, to tackle rising obesity levels.

2009: 'NHS health check', programme

This programme was intended to provide preventative health checks for developing health problems such as heart disease, stroke, kidney disease, and diabetes.

2009: 'Shaping the future of care together', green paper

This green paper provided a proposal for a new National Care Service and started the 'big care debate' as it set out funding alternatives for consideration.

2009: Quality, Innovation, Productivity and Prevention (QIPP), programme

The QIPP programme was a way of rising to Sir David Nicholson's 'challenge' for the NHS to achieve efficiency savings of £15–20bn by 2014/15.

2010: Marmot review

Sir Michael Marmot's 'Fair society, healthy lives' argued that the inequalities in healthcare were mostly preventable if the social determinates of health could be addressed.

2010: Health Committee's 2010 report into commissioning

The report was in response to further investigation into commissioning after questions were raised as to whether the existing system was effective.

2010: Equity and excellence: liberating the NHS, white paper

The white paper contained additional plans for structured reforms of public health, the NHS and social care systems.

2010: 'Health lives, healthy people', white paper

This white paper was directed at enabling people to enjoy healthier lives for longer and diminishing heath inequalities in society.

2011: Health Committee's 2011 report into commissioning

A report following on from the 'Equity and excellence' white paper which indicated disquiet around the 'significant institutional upheaval'.

2011: Health and Social Care Bill

The bill gave effect to the policies explored in the 'Equity and excellence' white paper opening NHS delivery to 'any wiling 'provider. The magnitude of the proposed changes attracted much disapproval, and the bill was heavily scrutinised. It received Royal assent in 2012.

2011: Public health responsibility deal

The 'deal' aimed to create partnerships between government, health organisations and business, with the aim of improving the health of the population.

2011: NHS Modernisation: listening exercise and NHS Future Forum

The government ceased parliament's scrutiny of the Health and Social Care bill and instead introduced an independent forum to scrutinise the bill.

2011: Law Commission report on Adult Social Care

Following on from public consultation, the Commission determined that the legal framework for social care was too fragmented and recommended extensive reforms.

2011: Fairer care funding? (Dilnot Report)

The Commission on Funding of Care and Support concluded that the adult social care system was in need of additional funding and a cap on the cost of care.

2011: Three new arm's-length bodies

The Health Research Authority, Health Education England and NHS Trust Development Authority were created as Special Health Authorities.

2012: The Public Health Outcomes Framework for England, 2013-2016

The framework provided a set of indicators in support of health protection and health improvement, and to lessen health inequalities.

2012: Health Select Committee and Local Government Association

In advance of the 'Caring for our future' white paper, these independent bodies published a review of the social care system and made recommendations for its reform.

2012: Health and Social Care Act, 2012

The Act became law following the 'pause' during scrutiny by the House of Commons and a slow and difficult route through the House of Lords. It created the NHS as an independent statutory body and replaced Primary Care Trusts with Clinical Commissioning Groups.

2012: 'Caring for our future', white paper and draft Care and Support Bill

The government set out plans for adult social care reform and published responses to the Dilnot and Law commissions.

2012: Consultation on minimum unit pricing of alcohol and a ban on multi-buy offers

The Home Office initiated a consultation on reforms to 'tackle binge drinking'. Subsequent plans were later cancelled.

2012: Personal Health Budgets (PHBs) roll out

Minister of State for Health Norman Lamb made public the national roll-out of PHBs, after independent evaluation concluded that they were frequently cost effective.

2013: National Health Service (procurement, patient choice and competition) Regulations, 2013

The government amended the draft regulations following concerns raised in the House of Lords, but defeated the opposition's attempt to overturn the regulations.

2013: Government announcement of social care funding reform

The Secretary of State set out proposals which included a lifetime cap on care costs.

2013: Antimicrobial resistance

Chief Medical Officer Dame Sally Davies in her annual report of 2013, highlighted concerns about the speed of antibiotic development and the potentially 'catastrophic' threat posed by antibiotic resistance.

2013: Public Health England (PHE)

The executive agency PHE was created and became responsible for improving and protecting public health.

2013: Plans to drive 7-day services across the NHS

Professor Sir Bruce Keogh laid out plans for 7-day services after research indicated very varied outcomes for patients admitted to hospitals out of hours.

2014: Framework agreement between the Department of Health and NHS England

The framework set out, for the first time, the means by which the Department of Health a nd NHS England would work together.

2014: Care Act, 2014

Building on the recommendations from the Law Commission, Dilnot Commission, and the Francis inquiry, the Act combined previous care legislation. It included placing a statutory duty of wellbeing on local authorities.

2014: Achieving Better Access to Mental Health Services by 2020, policy paper

Policy paper by the Department of Health announcing waiting time standards for mental health services for the next five years.

2014: NHS Five Year Forward View

This five-year plan set out changes to the NHS intended to encourage health and wellbeing, improve the quality of care and meet challenges.

2014: Dalton Review

Sir David Dalton's report 'Examining new options and opportunities for providers of NHS care' provided a series of options such as new organisational models, intended to achieve high quality and sustainable care.

2015: Improving GP services: Commissions and patient choice

2015: Healthy new towns

NHS England and Public Health England asked local authorities, housing associations and the construction sector to suggest development projects where the NHS could support the creation of health-promoting new towns and neighbourhoods in England. Initially, up to five projects would be selected.

2015: Better leadership for tomorrow: NHS leadership review

A review of leadership in the NHS, the final report made 19 recommendations including training, performance management, bureaucracy, and management support.

2015: Delays to phase two of the Care Act, 2014

The government postponed implementing legislation to reform social care funding. In 2017, implementation was postponed indefinitely.

2015: New regulations to make smoking in cars carrying children illegal

Regulations came into operation so that both the driver and the person smoking — if different people — could be fined £50.

2015: 'Sugar Reduction: The evidence for action', review

Public Health England published evidence on interventions to reduce sugar consumption following Health Select Committee demands for action.

2015: Transforming Care – building the right support

A national plan set out targets with the aim of reducing inpatient provision of care for people with learning disabilities and autism.

2015: 'Childhood obesity – brave and bold action', Health Select Committee inquiry

Inquiry into childhood obesity recommending a childhood obesity strategy to improve children's health and life chances.

2016: Cities and Local Government Devolution Act, 2016

This Act advanced health devolution by enabling the devolution of public body functions to local authorities and combined authorities.

2016: 'Every breath we take: the lifelong impact of air pollution', report

The Royal College of Physicians and Royal College of Paediatrics and Child Health reviewed evidence on the effects of air pollution on health. In this report, they made a number of recommendations aiming to reduce harmful impacts.

2016: Soft Drinks Industry Levy (SDIL)

Announcement of a manufacturer's levy on added sugar drinks from April 2018.

2016: Human papilloma virus (HPV) vaccination offer extended

The government introduced two new national HPV vaccination programmes: aimed at men who have sex with men and for all boys aged 12—13.

2016: National Living Wage (NLW)

The introduction of a new NLW for workers aged 25+, set at £7.20, provoked discussion around the potential additional costs this would place on adult social care.

2016: Standardised Packaging of Tobacco Products Regulations, 2015

Legislation for plain packaging for cigarettes came into force with the aim of reducing smoking rates.

2016: Human papilloma virus (HPV) primary screening

The government announced changes to the cervical screening methods with samples to be screened for HPV first, in the hope of improving the accuracy of such tests.

2016: Childhood obesity: a plan for action

The government published a 'plan for action' on childhood obesity emphasising its commitment to introduce a UK tax for producers and importers of soft drinks based on their sugar content from April 2018. It included a voluntary scheme for the food and drink industry to take 20% of sugar out of nine categories of food and drink by 2020. However, it faced criticism from the third sector, media, and industry, because of the voluntary nature of the sugar reduction.

2016: Public health post-2013 inquiry

The Health and Social Care Select Committee reports on its inquiry into public health post-2013. The inquiry found that authorities were 'trying to deliver more with less' and recommended that health implications were considered across all government policies. The Government faced criticism when it responded agreeing with some of the Committee's recommendations but did not commit to maintaining or increasing funding.

2016: Sustainability and Transformation Plans (later Partnerships)

NHS shared planning guidance had asked local health and care systems to jointly create 5-year, 'place-based' Sustainability and Transformation Plans (STPs) for how the changes set out in the Forward View would be implemented.

2016: Increase to the adult social care precept

The then Secretary of State for Communities and Local Government, Sajid Javid, announced an increase to the social care precept by raising council tax levels in each area up to 3%.

2017: Health and social care integration, report

National Audit Office (NAO) published the 'Health and social care integration' report. The report reviewed progress made by the Department of Health, the Department for Communities and Local Government, and NHS England on merging health and social care services, and included a focus on the first year of implementation of the Better Care Fund.

2017: Next Steps on the NHS Five Year Forward View and Accountable Care Organisations

The report set out a 5-year plan for the NHS and the way it could adapt to changing health needs. In the plan, NHS England highlighted funding challenges and outlined proposed moves towards integration. Questions were raised about the feasibility of improving services with no increase in funding for the NHS.

2017: Towards a smoke-free generation: a tobacco control plan for England

The Department of Health laid out plans to reduce smoking rates in its tobacco control plan. This included several national ambitions and made commitments for the end of 2022. The strategies included: a 'whole system approach' to tobacco control; improving public awareness, stop smoking services, and retaining tobacco taxes. The plan also included a smoke-free NHS by 2020 with trusts to encourage people using, visiting, or working in the NHS to quit.

2017: UK Air Quality Plan

In November 2016, the High Court ruled that the government's 2015 plan for reducing air pollution was illegal because it failed to take sufficient measures to improve air pollution 'as soon as possible'. In response, in May 2017 the government published a draft air quality plan to reduce nitrogen dioxide levels, and a national air quality plan on 26 July 2017. The plan was poorly received with the Royal College of Physicians describing it as a missed opportunity and calling on the government to do more.

2017: The Prevention Concordat for Better Mental Health Programme

This national agreement sought to mobilise system-wide implementation of a preventative approach to mental health problems and promotion of good mental health.

2017: Improving lives: the future of work, health and disability, policy paper

The Department for Work and Pensions and the Department of Health initiated a consultation 'Improving Lives: The Work, Health and Disability Green Paper' aiming to close the gap between employment rates for people reporting a disability and people who do not by 2020.

2018: The Department of Health and Social Care

The Department of Health became the Department of Health and Social Care (DHSC) with the name change intended to elevate the government's priority issue. There was limited shift in responsibilities, but DHSC took over from the Cabinet Office in preparing the government's much anticipated green paper on options for reforming adult social care.

2018: Carers Action Plan 2018-2020

On 5 June 2018, the government published a 'Carers Action Plan 2018-2020 — Supporting carers today,' the purpose of which was to set out a short-term programme of action to support unpaid carers, ahead of the green paper.

2018: Long-term funding of adult social care, report

The select committees for Health and Social Care and Housing, Communities and Local Government published a joint report on long-term funding of adult social care. This summarised evidence from their inquiry on funding reforms which was to contribute to the proposed social care green paper. The report described the existing funding, demand, cost, and workforce pressures on the social care system. It included estimates that there would be a social care funding gap of between £2.2bn—2.5bn in 2019/20.

2018: Climate Change: Second national adaptation programme (2018 to 2023)

The Department for Environment, Food & Rural Affairs (DEFRA) policy paper contained key national actions in readiness to cope with climate change over the next 5 years. The national adaptation programme set out the actions for government and others to tackle urgent risks identified in their 2017 Climate Change Risk Assessment (CCRA) impacting the natural environment, infrastructure services, buildings, homes, local governments, and businesses.

2018: 'Prevention is better than cure: our vision to help you live well for longer'

The Department for Health and Social Care laid out plans to improve healthy life expectancy by preventing ill health.

2018: Modernising the Mental Health Act: increasing choice, reducing compulsion

Publication of an independent review of the Mental Health Act, 1983. The government committed to reforms to tackle rising detention rates.

2019: NHS long-term plan

At the NHS' 70th birthday the government committed to increase funding for the NHS England and followed this with a 10-year plan. Key commitments included: improved early years, investment in mental health, and prevention of major health problem.

2020: 30 January: Coronavirus Risk level raised from low to moderate

The Chief Medical Officer, Chris Whittey, raised the risk level to the public from low to moderate allowing for an escalation in planning.

2020: 31 January: First cases of COVID-19 confirmed in UK

Chief Medical Officer, Chris Whittey, confirmed two cases of COVID-19 in the UK.

2020: 26 February: COVID Response Plan

The then Secretary of State for Health and Social Care, Matt Hancock updated parliament on the government's four-part plan to respond to the COVID-19 virus: contain, delay, research, mitigate. The UK was at this point in phase 1: 'contain' to limit the strain. The plan is published in March.

2020: 12 March: Shift from contain to delay phase of COVID-19 Response Plan

Government announced the shift from phase 1: 'contain' to phase 2: 'delay' of the COVID Response plan. It also announced policy of self-isolation for anyone with symptoms.

2020: 19 March: Coronovirus Bill, 2020

Emergency legislation to support COVID-19 response. Included measures to contain the virus such as closing schools and support for the economy. It became an Act on the 25th of March 2020.

2020: 23 March: Lockdown announced

The then Prime Minister, Boris Johnson, announced the first lockdown. People were only allowed to leave their homes for a small number of purposes (shopping for basic necessities, one form of exercise a day, any medical need, to provide care or help for a vulnerable person, or travelling to and from work where absolutely necessary). The police had powers to enforce these rules (fines, dispersing gatherings). Measures also included:

- Closing all shops selling non-essential goods
- Stopping all gatherings of more than two people in public, excluding people from the same household
- Stopping all social events

2020: 10 May: COVID-19 Alert System

The then Prime Minister, Boris Johnson, set out an alert system. The alert system comprised 5 levels, determined by the R number (the basic reproduction number, or the number of people that one person with an infectious disease will likely infect) and set out social distances measures.

2020: 1 May: 'Our plan to rebuild' published

Government's plan for recovery in light of COVID-19.

2020: 8 December: NHS delivers the world's first COVID-19 vaccination

Margaret Keenan received the first Pfizer COVID-19 vaccine, at Coventry University Hospital, following its clinical approval.

2020: Tackling obesity: empowering adults and children to live healthier lives

Government strategy to tackle obesity in the wake of COVID-19 pandemic. Included: introducing a new campaign for everyone who is overweight to take steps to move towards a healthier weight, with evidence-based tools and apps with advice on how to lose weight and keep it off.

2021: The future of health and care, white paper

The white paper set out the plan to put integrated care systems on a legislative footing and change the number of local NHS organisations that plan and pay for healthcare in England.

2021: Build back better: Our plan for health and social care, policy paper

The Build Back Better plan set out a number of Government initiatives designed to strengthen the NHS and social care and recover from the pandemic. Funding for new initiatives was drawn from a proposed new 1.25% Health and Social Care Levy that was ringfenced for health and social care from April 2023, and based on National Insurance (NI) contributions.

2021: People at the Heart of Care: Adult social care reform, white paper

Government white paper outlining plans for the next 10 years of adult social care. It included proposals on how to cap adult care costs.

2022: Health and Care Act, 2022

Public Health England was abolished and replaced with the UK Health Security Agency (UKHSA and the Office for Health Improvement and Disparities ((OHID)).

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