



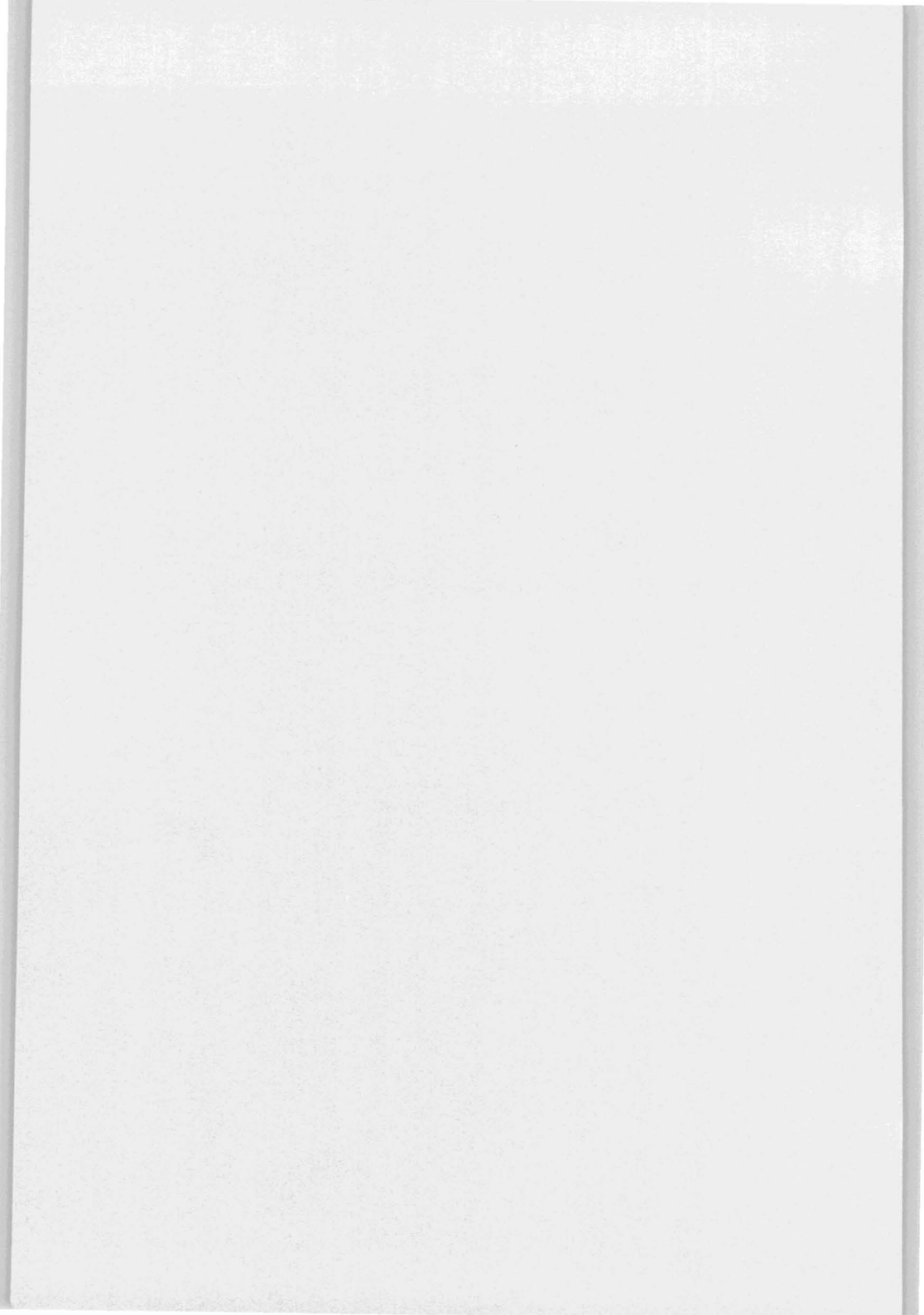
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**SOCIAL RISK AND SOCIAL WELFARE
IN BRITAIN, 1870-1939**

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SOCIAL RISK AND SOCIAL WELFARE IN BRITAIN, 1870-1939

Introduction

The dominant theme of virtually all studies of the long-run development of social welfare in Britain since the mid-Victorian period has been the increasing role of the central government in the public provision of welfare resources and services. In the 1960s and 1970s the development of 'the welfare state' was seen in predominantly whiggish terms, as one element of a generally positive and beneficent process of modernisation.¹ More recent studies have been equally confident of the long-term trend towards central state provision, though they have been less certain that the trend has been either desirable or beneficial for the welfare recipients. The expanding welfare role of central government has been variously interpreted as an example of bourgeois social control, of capitalist domination, and of an illiberal step down the road to serfdom.² International comparative studies have given equal or even greater emphasis to the process of central state provision of welfare, and have identified the driving force of this process as either bureaucratic self-interest or democratic political pressure mobilised through labourist political parties or more diffuse processes of state formation or the political articulation of 'actuarial factions'.³ The great diversity

¹. For example M. Bruce, The Coming of the Welfare State (London, 1961); B.B. Gilbert, The Evolution of National Insurance in Great Britain: the Origins of the Welfare State (London, 1966); D. Fraser, The Evolution of the British Welfare State (London, 1970).

². K. Williams, From Pauperism to Poverty (London, 1981); J.R. Hay, The Origins of the Liberal Welfare Reforms 1906-1914 (London, 1975); D.G. Green, Working-Class Patients and the Medical Establishment (Aldershot, 1985).

³. Examples of these four views can be found in: H. Hecló, Modern Social Politics in Britain and Sweden. From Relief to Income Maintenance (New Haven, 1974); G. Esping-Andersen and W. Korpi, 'Social Policy as Class Politics in Post-War Capitalism: Scandinavia, Austria and Germany' in J.H Goldthorpe (ed.), Order and Conflict in Contemporary Capitalism (Oxford, 1984); P. Flora and J. Alber, 'Modernization, Democratization and the Development of Welfare States

of these interpretations and putative explanations of the long run history of welfare provision does not diminish the remarkable concurrence that it is the centralising trend that needs to be explained.

This agreement over the object of study derives from the overwhelmingly *étatist* orientation of modern historians of welfare. Although simple and linear progression from 'individualism' to 'collectivism' is no longer acceptable or accepted, the dominance since the Second World War of public provision of health and social services, of education, and of income support in times of sickness, incapacity, unemployment or old age, has had a profound affect on the way in which historical questions are identified and interrogated. The rise of state welfare provision is the paradigm against which both comparative and national studies are set. Much North American writing on the history of welfare is quite consciously directed towards explaining and justifying why the United States did not enthusiastically follow the West European path towards more extensive public provision. In Britain historians have lavished attention on the transition from free market to collectivist welfare systems in the late nineteenth and early twentieth centuries. There have been dissenting voices from these more common views; in the case of the United States Michael Katz has shown that public welfare efforts were much more significant than has often be believed,⁴ and José Harris has recently remarked that the antagonisms and antitheses between free market and interventionist conceptions of welfare provision in Britain have frequently

in Western Europe' in P. Flora and A.J. Heidenheimer (eds.), The Development of Welfare States in Europe and America (New Brunswick, 1981); P. Baldwin, The Politics of Social Solidarity (Cambridge, 1991).

⁴. Michael Katz, 'Public Private Relations in the Shaping of Social Welfare in America: An Overview', paper prepared for Bad Homburg conference, March 1990.

been overdrawn.⁵ Nevertheless the historical picture is too often crudely two-dimensional, and it is so not just in terms of the organising concepts and categories used, but also in terms of the supporting evidence. Institutions, particularly public institutions that have a clearly recorded genesis, provide neatly delineated evolutionary pathways from initial idea to ultimate enactment for the historical enquirer to follow. David Thomson has made the point pithily:

Legislative enactments, parliamentary debates, press statements, pressure group publications, committee minutes, administrative directives - in short all the long-accepted resources of the historian - continue as the stock-in-trade of the welfare historians. The concern remains to establish who said what to whom and why, rather than with measuring and assessing who got what from whom, when, how often, and at what cost to giver, receiver or society at large.⁶

This paper will attempt a different approach. In order to avoid the étatist framework of most welfare history which almost necessarily undervalues, and often denigrates, private welfare initiatives, the starting point will be an analysis of the array of social risks faced by individuals and families in Britain between 1870 and 1939. Ways of responding to or coping with these risks will then be assessed according to methods of finance, of management, and of risk-sharing. The paper will show that the most common response to social risks in Britain in this period was private rather than public, collective rather than individualistic, and local rather than national.

Categories of social risk

Social risk derives from the changing and uncertain world in which individuals

⁵ J. Harris, 'Society and the State', pp. 63-117 in F.M.L. Thompson (ed.), The Cambridge Social History of Britain 1750-1950: Volume 3 (Cambridge, 1990).

⁶ D. Thomson, 'Welfare and the Historians', pp. 355-78 of L. Bonfield, R.M. Smith and K. Wrightson, The World We Have Gained (Oxford, 1986), pp. 355-78. Quotation from p. 357.

live. What counts as risk is to some extent a cultural construction, as is the way in which some risks come to be perceived as social problems.⁷ In consequence the perceived incidence of risk will vary not only between individuals, but also between different places, different cultures and over time. All risks can, however, be thought of schematically as falling into one of four categories relating to health, life-cycle stage, economy and environment, and the strategies adopted to accommodate these risks, whether individual or collective, private or public, form the welfare structures of any society. Across the industrial societies of the later nineteenth century the perception of social risk was similar, even though there was considerable variation in the national responses to these risks.⁸

The most significant individual risk related to health. High nineteenth-century mortality rates are the clearest indication that life was chancier in the past than it is today. Although overall mortality rates were strongly influenced by very high levels of infant mortality, adult mortality was also high; fewer than half of all 20-year-olds in Victorian Britain could expect to survive to age 65.⁹ Whether the Victorian population was less healthy than the modern population, as well as less long-lived, is a matter of debate. James Riley has suggested that the great increase over the last hundred years in the survival chances of the less fit may have reduced the overall health of the population, but the morbidity data on

⁷. M. Douglas and A. Wildavsky, Risk and Culture (Berkeley, 1982); N. Manning, 'Constructing social problems' in N. Manning (ed.), Social Problems and Welfare Ideology (Aldershot, 1985), pp. 1-28.

⁸. Baldwin, Politics of Social Solidarity, passim.

⁹. M. Anderson, 'The impact on the family relationships of the elderly of changes since Victorian times in governmental income-maintenance provision' in E. Shanas and M.B. Sussman (eds.), Family, Bureaucracy and the Elderly (Durham, N.C., 1977), p. 39.

which this argument rests is far from representative.¹⁰ It is, nevertheless, clear that among small groups of skilled workers the incidence of sickness in any annual period in the later-Victorian period was very high, and the widespread incidence of the normal diseases of childhood, together with the ever-present fear of tuberculosis, makes it seem likely that all people were touched by recurrent acute illnesses, while many suffered from chronic conditions.¹¹

Life-cycle risks reflect the evolving needs and capacities of family or household units. The extra costs associated with child birth and child rearing, frequently accompanied by a fall in family income as mothers were forced to relinquish paid employment, was the most widespread familial or life-cycle risk. The cyclical nature of family poverty, and the specific risk of poverty in young families with many dependent children, was highlighted in 1901 with the publication of Seebohm Rowntree's investigation of poverty in York.¹² He found that largeness of family was the second most important cause of primary poverty, after low wages. However, it was not only the young who faced life-cycle risks; declining strength and earning power in old age could combine to create both economic and physical want. Both these life-cycle risks could be amplified by family dissolution through separation or death of a partner.

Economic risks are endemic to industrial societies in which consumption needs are more stable than is employment income. Fluctuating rates of pay, hours of work

¹⁰. J. Riley, 'Working health time: a comparison of preindustrial, industrial and postindustrial experience in life and health', Explorations in Economic History 28 (1991), pp. 169-91; J. Riley, Sickness, Recovery and Death (Iowa, 1989).

¹¹. H. Southall and E. Garrett, 'Morbidity and mortality among early nineteenth-century engineering workers', Social History of Medicine (1991), pp. 231-52; F.B. Smith, The Retreat of Tuberculosis (London, 1988).

¹². S. B. Rowntree, Poverty, A Study of Town Life (London, 1901).

and employment opportunities all created substantial economic risks for manual workers which were much more severe than those suffered by salaried workers with their more secure employment contracts, or by capital owners with reasonably stable income streams. This economic instability stimulated a wide range of private and public risk-sharing strategies in the period covered by this paper but, as will be shown below, there was no simple transition from individualism to collectivism. Finally, environmental risks include not only storm, flood, tempest and other 'acts of God', but also the risks associated with social living, particularly the risks of accident, of fire and of theft. Most of these risks have been viewed as personal rather than social in modern industrial societies, though there is no necessary reason why they should be treated in this way.

By examining the way in which people in Britain responded to these four types of risk, and by tracing the changes in these responses over the period 1870-1939, this paper will show how public and private welfare systems sometimes complemented and sometimes competed with each other. The interrelationship is complex, and this complexity is a better representation of how alternative welfare strategies were made use of by ordinary people than is the neatly compartmentalised view of social welfare presented in institutional histories.

The nature of each of the different responses is as complex as is their interrelationship. Terms such as 'individualist' and 'collectivist' that were widely used in late-Victorian and Edwardian discussions of social issues and policies are imprecise when applied critically to the discussion of strategies to cope with differential risk.¹³ From an economic standpoint, any strategy that involves risk-pooling is collective regardless of whether the underlying financial principle is that of reciprocity or redistribution; putting money in a savings account is

¹³. These terms were ambiguous even within the parameters of the then-contemporary debate; for a discussion see M. Freedon, The New Liberalism (Oxford, 1978).

individualistic, buying an insurance policy or paying contributions to the local poor law are both collective.¹⁴ But whereas the collective risk-pooling of commercial insurance companies was and is strictly circumscribed by contractual rules designed to minimise all but actuarially intentional redistribution, the Victorian poor law was by contrast a non-contractual collective scheme deliberately designed to redistribute from richer to poorer citizens.

The degree of redistribution in any insurance scheme is not a direct function of whether the scheme is administered publicly or privately, but instead depends on how strictly contractual is the insurance relationship; detailed contracts tend to emphasise actuarial fairness. As will be outlined below, a number of twentieth-century public welfare initiatives which are often represented as evidence of a move towards 'collectivism' in fact introduced more contractual forms of insurance in which returns were closely matched to contributions. In order to avoid confusion over the several meanings of the term 'collective', this paper will instead distinguish between contractual insurance or welfare systems in which benefits are strictly linked to contributions, and solidaristic insurance or welfare systems in which benefits are related to desert within a particular risk pool, however defined. In practice, of course, most insurance and welfare can be found at some point on a spectrum between these two extremes.

Health risks

Poor health could impose a double burden on a family, in terms of both medical fees and lost earnings. The risk of poor health was so high, and the cost potentially so burdensome, that most families made some attempt to share risks and costs by joining a medical insurance scheme. This was true throughout the period 1870-1939, and was not altered in a fundamental way by the introduction

¹⁴. For a summary of the economic approach to insurance and redistribution, see N. Barr, The Economics of the Welfare State (London, 1987), chs. 4 and 5.

of contributory national health insurance in 1911. Some of the risks of ill health were also met by an extensive range of charitable institutions, particularly where treatable disease or injury required hospitalisation. This 'mixed economy' of medical service provision was fundamentally challenged only during the Second World War by the establishment of the wartime Emergency Medical Service, and by the creation of a universal, tax-financed National Health Service in 1948.¹⁵

Medical attention did not come cheap in Victorian Britain. Then as now prestigious doctors charged prestigious patients fees to match their economic and social status; poor patients were charged more reasonable rates which in the 1870s were between 2s. 6d. and 5s. per visit.¹⁶ With these fees a sustained bout of familial ill-health could be financially crippling. In the mid-1870s a labourer was successfully sued for £12 15s. - around a quarter of his annual income - for medical services during a period of fever, charged by the doctor at the rate of 3s. per visit plus 1s. travel.¹⁷ Where it was the breadwinner who had succumbed to sickness, the collapse of family income quickly led, via the pawnshop, to destitution and either charitable or poor law assistance.¹⁸ Given the exceptionally high cost of individual payment for medical services it is little wonder that strenuous attempts were made by many millions of working-class families to purchase insurance against such calamities.

¹⁵. R. Titmuss, Problems of Social Policy (London, 1950); C. Webster, Problems of Health Care: The National Health Service before 1957 (London, 1988).

¹⁶. F.B. Smith, The People's Health (London, 1979), p. 370.

¹⁷. *Ibid*, p. 373.

¹⁸. See, for example, the evidence in the following Charity Organisation Society case papers covering the period from the 1870s to 1939, lodged in the Greater London Record Office: Area 1, box 1, case 10409; box 2, case 15194; box 3, case 10788; box 4, case 16735; box 7, case 37/358.

Health insurance in this period came in many guises and was offered through a multiplicity of institutional forms. The complexity of provision precludes any exact calculation of the extent or cost of coverage, but by piecing together the evidence some rough estimates can be made. At the top of the hierarchy of sickness insurance institutions were the major friendly societies which provided medical attention and sick pay for members who were prevented from working by illness, together with funeral benefits and lying-in benefits for members' wives who were in the final stages of pregnancy. Some societies were confined to members of a particular profession, industry or trade, some to a particular locality, but the basic insurance principle of spreading the risk as widely as possible encouraged the growth of national societies, the two largest being the Independent Order of Oddfellows and the Ancient Order of Foresters. In 1901 societies offering a full range of sickness benefits had 4.1 million members in England and Wales, equal to 41 per cent of the male population aged 20 and over. This figure rose to 4.4 million in 1911 and 4.5 million in 1931, by which time the proportion of the adult male population covered had fallen to just under one third.¹⁹ These friendly society members were almost exclusively males and were mainly clerical and better-paid manual workers; according to Gilbert '[f]riendly society membership was the badge of the skilled worker'.²⁰ The major constraint on membership was probably cost. Contributions of 6d. to 1s. per week, depending on age of entry, required an income that was both reasonably high and reasonably stable. In return, sick pay of up to 14s. per week would typically be offered for the first 13 weeks, reducing to half pay for a further 39 weeks and sometimes quarter pay thereafter.

¹⁹. P. Johnson, Saving and Spending: the Working-Class Economy in Britain 1870-1939 (Oxford, 1985), p.57. A slightly higher estimate of 4.75 million members in 1910 was made by William Beveridge, Voluntary Action (London, 1948), p. 76.

²⁰. Gilbert, Evolution, p. 167. See also Johnson, Saving and Spending, pp. 57-63.

These societies combined a mixture of contractual and solidaristic insurance. As already noted, limits were put on the length of time full benefit could be drawn, and by the end of the nineteenth century most societies (but not the temperance friendly societies) required prospective members to undergo a formal medical test in order to limit bad risks. In practice, however, the keenness of societies to recruit new members, particularly if connected by family or through work to an existing member, made the contractual rules very flexible.²¹ This flexibility, together with the fraternal sentiments that were an important element of the friendly society movement, made the societies much more solidaristic than their formal rules indicate. Generous payments were made to long-standing members because of their fraternal status, even though they had often ceased to qualify for sick pay. This solidaristic approach to sickness insurance which resulted in societies in effect paying disability pensions to some of their older members was, by the end of the nineteenth century, driving many societies towards actuarial insolvency, and was one reason why their opposition to state old age pensions was so muted.²²

But what of the rest of the population, 'more than three fourths' according to the Minority Report of the Royal Commission on the Poor Laws, whose sickness was not covered by the provisions of the major friendly societies?²³ At least 300,000 people, and possibly as many as 4 million were eligible for medical services (but not sick pay) provided by medical friendly societies, both registered and

²¹. Green, Working-Class Patients, pp. 102-4.

²². B.B. Gilbert, 'The decay of nineteenth century provident institutions and the coming of old age pensions in Great Britain', Economic History Review 2nd series, vol 17 (1965).

²³. Royal Commission on the Poor Laws and Relief of Distress, Minority Report, PP 1909 XXXVII, p. 870.

informal.²⁴ Even on the highest of these estimates, of course, very few women and children would have been covered. Yet there were other, private, mechanisms for the purchase of medical insurance which prevented recourse to charity or the poor law. In addition to the registered and unregistered friendly societies, medical attendance insurance was variously available from companies such as the National Medical Aid Co., schemes set up by private individuals, and schemes operated by a doctor or group of doctors themselves.²⁵ The Lancet claimed that in many towns between two thirds and three quarters of the population belonged to medical aid organisations of one sort or another²⁶, and a long campaign was waged by the medical establishment against such organisations which contracted doctors to treat their members for an average fee in 1905 of 4s. 4d. (a penny a week).²⁷ By 1913 it has been estimated that half of Britain's 20,000 general practitioners were engaged in contract practice.²⁸ The Friendly Societies Medical Alliance recommended that one doctor should not be contracted to serve more than 2500 patients, although 4000 patients per doctor were not unknown.²⁹ Putting these two sets of estimates together suggests medical coverage for at least 25 million people in 1913, and possibly as many as 40 million, or something between 60 and 95 per cent.

This discussion of medical insurance has shown that private provision for ill health was very extensive well before the introduction in 1911 of the national health

²⁴. Johnson, Saving and Spending, p. 56; Green, Working-Class Patients, p. 95.

²⁵. (The Lancet), The Battle of the Clubs (London, 1896), pp. 97-104.

²⁶. Ibid, pp. 117, 123, 180.

²⁷. Green, Working-Class Patients, p. 48.

²⁸. F. Honigsbaum, The Division in British Medicine (London, 1979), p. 13.

²⁹. Green, Working-Class Patients, p. 39.

insurance scheme, and it continued to be an important part of people's strategies to cope with the cost of illness throughout the inter-war period. Yet contract medical practice did not serve all cases - it was too costly for the very poor, too limited for the very sick. For these cases there was charity or the poor law. Charitable assistance for the sick came in two main forms - provident dispensaries and voluntary hospitals. Provident dispensaries were semi-charitable in that those who were willing to pay a weekly contribution (often a penny per person) received treatment on what was effectively a contract insurance basis, while the very poor were required to pay only a token sum, with the balance supplied by honorary members.

Of greater importance were the voluntary hospitals which, in their outpatients departments, dealt with enormous numbers of people. In 1900 the London voluntary hospitals were said to be treating 1.9 million out-patients annually, rather more than their endowment income could sustain.³⁰ In 1874 the London hospitals were driven by financial need to establish a Hospital Saturday Fund which collected small weekly sums from workers and gave tickets to contributors which allowed them to nominate deserving cases or escape registration fees.³¹ In the interwar period this arrangement became more formalised in the Hospital Savings Association, which operated rather like a contract insurance scheme; membership in London reached 1.9 million by 1938, by which date total national membership of Hospital Saturday Funds and organized workmen's collections had reached 10.3 million.³² The voluntary hospitals continued to provide free treatment to out-patients they considered to be deserving. This concept of

³⁰. Smith, People's Health, p. 251.

³¹. G. Rivett, The Development of the London Hospital System 1823-1982 (London, 1986), p. 122; B. Abel-Smith, The Hospitals 1800-1948 (London, 1964), pp. 135-6.

³². The Hospitals Yearbook 1940, pp. 289-300.

charitable desert was initially introduced at University College Hospital in London which in 1872 invited the Charity Organisation Society to vet out-patients in order to determine their ability to pay.³³ The practice was subsequently extended, formalised and generalised through the hospital almoner system.³⁴

For those who could not pay and who could not get access to appropriate treatment through the voluntary hospitals (which were concentrated in the larger cities) there were the poor law medical facilities. These appear to have been a place of last resort, at least in the nineteenth century. Although the Medical Relief Disqualification Removal Act of 1885 gave the (otherwise enfranchised) sick pauper the vote, it did not free poor law medical care from all stigma. In the 1920s it was still necessary for every patient entering a poor law infirmary to obtain an admission order signed by the relieving officer, and in London it was claimed that some patients would wait months for a place in a voluntary hospital despite the ready availability of equivalent poor law facilities.³⁵ The provision for transfer of the hospital functions of the poor law to the Public Health Committees of local authorities by the 1929 Local Government Act removed the element of formal pauperization in those parts of the country where the transfer took place³⁶, but it did not do away with the means test. Local authorities had an obligation to charge for treatment in general hospitals, and were able to make husbands liable for wives, parents for children under 21.³⁷ Nevertheless, the income they raised through payments was small. In 1934 the income of voluntary

³³. Smith, People's Health, p. 278.

³⁴. Hospital Almoners' Association, The Hospital Almoner (London, 1935)

³⁵. Abel-Smith, The Hospitals, pp. 356-8.

³⁶. C. Braithwaite, The Voluntary Citizen (London, 1938), p. 18.

³⁷. Abel-Smith, The Hospitals, p. 374.

hospitals was £14.2 million, of which 41 per cent came from receipts for services rendered, but the public hospitals raised only 7 per cent of their £19.6 million from charges.³⁸

Some other medical services were even more mixed in their funding. District nurses were initially established on an entirely charitable basis, and until 1937 neither central nor local government had any general power to organise domiciliary nursing. Nevertheless, from 1892 poor law guardians were allowed to pay annual subscriptions to district nursing associations, and by 1907 almost 400 associations were being assisted in this way.³⁹

In the period from 1870 to 1939 the social risk of ill health in Britain was met by a complex network of overlapping systems for insuring against the costs of sickness and for providing medical attention. Personal attempts to insure against the costs ranged from solidaristic friendly society membership to the strictly contractual medical aid companies. In addition charitable assistance through voluntary hospitals and means-tested access to poor law dispensaries and infirmaries provided for those who had no insurance. Private effort was both widespread and financially significant; for instance in a social survey of Bristol conducted in 1937, 62 per cent of working class households were found to be contributing to a hospital fund.⁴⁰ Most of this private effort was organised at a local level and a good deal was self-managed. Where obvious gaps emerged, as with domiciliary nursing, charities and poor law authorities attempted to plug the gaps in a somewhat ad hoc manner.

³⁸. Braithwaite, Voluntary Citizen, pp. 171, 180.

³⁹. *Ibid.*, pp. 268-278.

⁴⁰. H. Tout, 'A statistical note on family allowances', Economic Journal L, march 1940, p. 58.

The introduction of national health insurance in 1911 for full-time manual workers probably did very little immediately to extend access to doctors, though it certainly did give many more men an entitlement to sickness pay. The tripartite contribution - from workers, employers and the government - was redistributive to a degree, but rather less so than most poor law or charitable medical services. The administration of the scheme according to strict rules by 'approved societies' made it a more contractual and less solidaristic form of insurance than was much friendly society sickness insurance. Although perhaps of considerable significance in terms of administrative innovation, in terms of who got what from whom, when, how often and at what cost, the health provisions of the National Insurance Act of 1911 were of less importance than private insurance. Even by 1938, National Health Insurance covered only 42 per cent of the population.⁴¹

Life-cycle risks

Life-cycle risks were those identified in Rowntree's poverty cycle as related to birth and infancy, and old age and death. In the 1870s neither life-cycle problem was considered to be the automatic responsibility of any public authority, although poor law infirmaries and workhouses did provide care for otherwise dependent pregnant women and aged men and women. In practice, however, the number of people receiving residential care was small. Thomson has shown that even in the peak year of 1901 the proportion of the age group 65-74 in poor law institutions stood at only 5.82 per cent for men and 2.81 per cent for women.⁴² There was, however, much more extensive financial support from poor law funds for the aged living in their own homes. Charles Booth estimated that in 1891 the proportion of men over 65 in receipt of any poor law relief was 39.5 per cent in London, 28.5

⁴¹. N. Whiteside, 'Private agencies for public purposes: some new perspectives on policy making in health insurance between the wars', Journal of Social Policy 12 (1983), pp. 165-94.

⁴². D. Thomson, 'Workhouse to nursing home: residential care of elderly people in England since 1840', Ageing and Society 3 (1983), pp. 43-70.

per cent in other urban and suburban areas, and 25 per cent in rural or semi-rural areas,⁴³ and Thomson has argued that 'over a lifetime, and especially near the end of it, all stood a very good chance of attaining the status of "pauper"'.⁴⁴ Striking though these estimates are, their most important conclusion is often overlooked - that for most of the time most aged people were not dependent on public support at all. Either they earned sufficient income in the labour market or received sufficient financial support from family, neighbours and friends or from savings to maintain an independent existence. Thomson is certainly right to emphasise both the low rates of co-residence of the elderly with kin together and the general acceptance in nineteenth-century Britain of public responsibility for aged dependants by poor law authorities⁴⁵, but his reliance on poor law evidence leads him to diminish the role of private provision and self-help.

It should be made clear that this majority of aged persons who lived lives independent of poor law support did not receive much from charitable sources. In 1909 charities specifically charged with providing pensions and homes for the aged in London received only £342,000, or just over 4 per cent of total charitable income in the metropolis.⁴⁶ By the 1940s endowed charities distributed approximately £5 million to old people, including, in 1943, pensions for just over 75,000 elderly people.⁴⁷ By this date public pensions were being paid to over 4

⁴³. C. Booth, The Aged Poor in England and Wales (London, 1894), p. 14.

⁴⁴. D. Thomson, 'Provision for the elderly in England, 1830-1908', University of Cambridge Ph.D. thesis, 1980, p. 16.

⁴⁵. D. Thomson, 'The welfare of the elderly in the past: a family or community responsibility?' in M. Pelling and R. Smith (eds.) Life, Death and the Elderly (London, 1991), pp. 194-221.

⁴⁶. Braithwaite, Voluntary Citizen, p. 104

⁴⁷. E. W. Cohen, English Social Services (London, 1949), p. 107.

million pensioners, at an annual cost of over £100 million.

The introduction of means-tested non-contributory public pensions for people over 70 in 1908 marked an important step in the development of central state welfare services. Although the pension served initially more to replace poor law out-relief than to provide additional financial support for the previously independent⁴⁸, in terms of finance and administration it broke new ground. Central exchequer finance and centralised administration (*faute de mieux* by the Customs and Excise, with payment made through the Post Office) were a fundamental departure from the local basis of poor law operation. Even so there was a need for local decision-making over individual cases relating to eligibility and the means test, and this local management was supervised by voluntary committees appointed by local councils.⁴⁹

Poor law pensions had been redistributive from (better-off) ratepayers to (worse-off) paupers and so were, like the rest of poor law provision, solidaristic in the sense that benefits were related to desert rather than contribution. The assessment of desert required personal knowledge from individual investigation which could only be undertaken locally. The 1908 non-contributory pension scheme further extended this principle of public solidarity but the need to discriminate between the deserving and the ineligible again required some local investigative capability. The move to full centralisation was accomplished in 1925 with the introduction of contributory national insurance pensions. These pensions required no local management because they were contractual rather than solidaristic - benefit was directly related to prior contribution, and character,

⁴⁸. P. Johnson, 'The employment and retirement of older men in England and Wales, 1881-1981', p.18 (forthcoming, Economic History Review, 1993).

⁴⁹. P. Thane, 'Government and society in England and Wales, 1750-1914' in Thompson (ed.) Cambridge Social History: volume 3, pp. 1-61.

income and personal circumstances were immaterial to the award of the pension. The tripartite contribution principle in the National Insurance fund meant that there was some element of redistribution in the contributory state pension scheme, but the redistributive intent was less marked than in either the 1908 pension scheme or in the earlier practice of giving poor law out-relief. Public financial support in old age had been transformed from a solidaristic system - in which the risk pool was the whole community, and in which contributions were levied on all households with benefits directed to citizens in need - to a contractual system in which a strictly defined risk pool (contributing manual workers) provided benefits for itself, with redistribution largely limited by the actuarial chance of longevity. This drift of public pension provision towards the principles and practice of commercial contractual insurance fits uneasily with simple historical notions that the rise of 'collectivism' involved the introduction of increasingly redistributive public welfare systems.

The increasingly contractual approach to public support for the elderly can be contrasted with a consistently solidaristic treatment of infants and children. Public involvement in childbirth and infancy was usually mediated through voluntary or semi-voluntary channels, and was seen as a local rather than a national responsibility. This was true even with such apparently straightforward national legislation as the 1902 Midwives Act, which devolved the funding and administration of midwife training to local public and private bodies. National guidelines, local implementation, and solidaristic funding in which the local community paid for the supply of services according to need rather than contractual entitlement was the basis of infant and child welfare provision.

The nature of state support for children after 1870 is in some respects the antithesis of public support for the elderly. Whereas out-relief and old-age pensions moved from the publicly solidaristic to the publicly contractual, education moved in the opposite direction, with schooling first being provided by

local school boards in 1870, made compulsory in 1880 and effectively made free in 1891.⁵⁰ Responsibility for (and the cost of) education gradually shifted from parents to the local community as financial risks of child-rearing were spread over a risk pool comprising all ratepayers in a school board district. Perhaps these divergent trends reflect a change in underlying social attitudes, with education increasingly being seen as a public good, an investment in future workers, while pensions were viewed more as a public burden.

This discussion of the role of public institutions in infant and child welfare must not, of course, be allowed to obscure the fact that the overwhelming responsibility for infant and child welfare lay in the private sector, with families. Although the state increasingly became involved with the issues of maternity and education, it was content to leave most of the financial, practical and moral responsibilities of child rearing to parents, and intervened only when death, desertion, cruelty or poverty created an obvious child welfare problem. Although the ideological climate was changing before the Second World War, the failure of the family endowment movement to obtain some version of a 'family wage' kept the cost of children firmly in the private sector.⁵¹ Not surprisingly many, perhaps most, parents attempted to spread and share these costs. Formal insurance provided no opportunities here - children do not represent a short-term, sporadic, actuarial risk - but family, friends and neighbours could all be called on to help in periods of need. The nature, extent and use of kinship and neighbourhood networks in providing regular or periodic child-care services is still an under-researched topic,

⁵⁰. S.J. Curtis, History of Education in Great Britain (7th ed., London, 1967), ch. 8.

⁵¹. J. Lewis, 'Models of equality for women: the case of state support for children in twentieth-century Britain' in G. Bock and P. Thane, (eds.), Maternity and Gender Politics (London, 1991), pp. 73-92.

but existing studies indicate that these networks were vital for many mothers.⁵² Although the spheres of home and work were less separate in the 1930s than they had been in the 1870s, the day-to-day care of children was almost exclusively the responsibility of women. How far the exchanges between women of goods, money and, above all, time, depended on carefully considered reciprocity rather than more purely charitable sentiments is unknown, but the underlying rules were certainly not those of a formal contract. Community solidarity meant that it was neighbours in the street, not officers of the state, who were most likely to help if a child was sick or a cupboard was bare.

Economic risks

Cupboards sometimes became bare even in the homes of highly-skilled workers who normally experienced regular work. Except for the fortunate few in railway company or government employment, job insecurity and short-time working were an economic scourge from which there was no escape. But if neither prevention nor cure lay within the scope of ordinary workers, protection did. Virtually all households accumulated assets - financial or real - which they could draw on or pawn in times of economic stringency. By 1900 there were over 10 million savings bank accounts in existence, and an estimated 200 million pledges a year made with pawnbrokers.⁵³ These personal or familial strategies were far more widespread than formal unemployment insurance provided through trade unions. In 1911 Lloyd George thought that 'not a tenth of the working classes have made any provision at all' for insurance against unemployment⁵⁴; according to figures collected by the government, trade union assistance of any sort in times of

⁵². See, for example, E. Ross, 'Survival networks: women's neighbourhood sharing in London before World War I' *History Workshop* 15 (1983), pp. 4-27; J. White, *The Worst Street in North London* (London, 1986), pp. 71-82.

⁵³. Johnson, *Saving and Spending*, pp. 92, 168.

⁵⁴. Hansard, 5th ser., vol xxv, cols 610-11 (4 May 1911).

unemployment was available to no more than 2.3 million workers in 1908.⁵⁵

Even within this relatively small insured group, the value of unemployment insurance varied widely between sectors, from the high levels in printing to the trivial in transport. Effective unemployment insurance was bound to be expensive in the precarious labour market of Victorian and Edwardian Britain, particularly so when conducted by trade unions which were ill-designed to spread risks and minimise costs. Given the trade-related nature of unemployment risks, an optimal risk pool would have been one that included workers from a variety of trades that experienced different cyclical employment patterns; as it was, trade unions compounded risks by uniting workers in a single trade. On the other hand, the solidaristic nature and purpose of trade unions enabled them to operate in a deliberately redistributive manner at times of special need such as during trade disputes and trade depressions. Special levies were imposed on those in work to provide for members temporarily laid-off or locked-out, and little attempt was made to run union funds on actuarial principles. Unions operated as 'pay-as-you-go' solidaristic insurance clubs, with subscriptions and levies adjusted from year to year to pay for the current level of benefits.

The introduction of a public unemployment insurance system by Part Two of the National Insurance Act of 1911 marked a decisive step towards state centralization, but as with the national health insurance scheme, the move was towards a contractual system. National unemployment insurance was compulsory for the 2.25 million workers in the designated industries of building, shipbuilding, mechanical engineering, ironfounding, saw-milling and vehicles, and tripartite contributions from workers, employers and the government ensured some

⁵⁵. J. Harris, Unemployment and Politics (Oxford, 1972), p. 298.

redistribution from both profits and central government revenue.⁵⁶ Levels of contribution and benefit were set by reference to past unemployment experience, the intention being that the scheme would break even over a mix of good and bad years. During the First World War unemployment insurance was extended to munitions workers and to virtually all manual workers by stages in 1920, 1927 and 1930. The government in effect directly acknowledged some responsibility for providing a safety net against the most common of economic risks, although this was done through a system of compulsory contract insurance with principles derived as much or more from the commercial insurance industry as from the trade union experience of fraternal solidarity.

The inter-war practice differed a good deal from the contract insurance principle. With unemployment among the insured population at over 10 per cent for all but one year between 1921 and 1938, and reaching a peak of 23 per cent in 1932, a scheme originally restricted mainly to skilled workers and initiated during a period of high employment was found wanting.⁵⁷ For most of the inter-war period the unemployment insurance fund was in deficit, and repeated bailing-out and topping-up by the government made the operation of public unemployment insurance in the 1920s and 30s much more solidaristic and redistributive than had been intended. As a consequence the original goals of broadening the tax base, of encouraging by compulsion a degree of private provision against economic uncertainty, and of separating unemployment benefits from means-tested public doles were all thereby compromised. This should not detract, however, from the very important role national unemployment insurance played after 1911 in creating a degree of protection against economic risks - albeit at a minimal,

⁵⁶. For details of the unemployment insurance scheme, see the essay by A.I. Ogus in P Kohler and P Zacher, The Evolution of Social Insurance, 1881-1981 (London, 1982), pp. 150-264.

⁵⁷. For details see W. Garside, British Unemployment 1919-1939 (Cambridge, 1990), chs. 2 and 3.

below-subsistence level - which had never before been available to the majority of the workforce.⁵⁸

Environmental risks

The final type of risk is that which comes from living in a physically hazardous world. The hazards can be entirely impersonal and exogenous - as with storm or flood - or largely personal and endogenous to a particular way of life - as with personal accident. Most of these risks have been viewed as unworthy of public insurance, though they have not been wholly untouched by local and central government action. Private insurance against damage to property by fire was the backbone of the non-life insurance business in the nineteenth century, though it was of little concern to working-class tenants.⁵⁹ Insurance against fire damage to personal rather than real property had little to offer manual workers, whose estates on death at the turn of the century were estimated to have an average value of no more than £16.⁶⁰ For similar reasons insurance against loss of personal property by theft was restricted to the relatively wealthy. Public action was limited to prevention rather than compensation of loss; in London, for example, public funds were spent on the Metropolitan Police Force from 1829 and the Metropolitan Fire Brigade from 1866.

Accident insurance was also conducted privately, but with an increasing amount of state direction. Personal accident insurance was a product of the growth of railway travel in the 1840s, but for workers accident insurance resulted from the

⁵⁸. Of workers insured in 1913, 63 per cent were skilled, but only 20 per cent had previously been covered by any sort of private out-of-work insurance. Harris, Unemployment and Politics, p. 360.

⁵⁹. B. Supple, The Royal Exchange Assurance (Cambridge, 1970), pp. 211-17.

⁶⁰. L.G. Chiozza Money, Riches and Poverty (London, 3rd ed. 1906), p. 51.

Employers' Liability Act of 1880 and the Workmen's Compensation Acts of 1897 and 1906. The first of these acts codified the common law liability of employers for injury sustained by a workman as a result of the negligence of his employer, but the 1897 act removed the need to demonstrate employer negligence. Asquith noted that the principle on which the legislation rested was 'that it is to the interest of the community as a matter of public policy, that the workman who sustains an injury in the course of his employment should, as far as money can do it, have the right to be indemnified. It is a new right you are creating for the workman, and a new obligation you are imposing on the employer.'⁶¹ Public authorities created a legal obligation on employers to recompense injured workers, which employers then pooled through commercial insurance companies. This combination of state paternalism and private insurance was, as far as the workforce was concerned, entirely non-participatory, yet it was obviously redistributive from employers to workers. It fits neither the solidaristic model of trade union insurance or poor law provision, nor the contractual model of national insurance or private health insurance, but it was an important and early example of central government action on social welfare issues.

Patterns of development in British social welfare

In this paper I have consciously taken a narrowly materialistic view of social welfare in Britain between 1870 and 1939, with the intention of addressing Thomson's question of 'who got what from whom, when, how often, and at what cost to giver, receiver, or society at large'. I have taken this approach not because I believe that ideology, political and economic pressures, social knowledge, the policy-making process or the aims and ambitions of key individuals are of lesser or no importance in the study of the evolution of social welfare, but because I think this view of welfare 'from the bottom up' can provide a useful

⁶¹. Quoted in H.E. Raynes, A History of British Insurance (London, 1964), p.294.

counterbalance to the more common politico-administrative studies. By first identifying the array of social risks faced by people in late nineteenth and early twentieth century Britain, and then by chronicling the strategies they adopted to counter these risks, I have tried to make three inter-related points.

First, most social risks were met, most of the time, by a complex array of private responses which included both the highly individualistic (private savings) and the highly solidaristic (fraternal insurance in trade unions). The relatively small numbers of people reliant on state support in the late nineteenth century (paupers accounted for about 2.6 per cent of the population in the 1890s) despite the unstable nature of the labour market is itself an indication of the extent of private welfare provision. Of all social groups it was the elderly who were most likely to become dependent on poor law assistance, yet as pointed out above the majority of the elderly remained independent of public financial support until the introduction of state old age pensions in 1908. Medical expenses continued to be met primarily by private insurance, with an additional direct supply of medical services from charitable sources, until the beginning of the second world war. The use of medical services provided by voluntary hospitals and district nurses was the most widespread form of voluntary charitable welfare service, but whether it was viewed by recipients in the same light as almshouses, soup kitchens and Salvation Army hostels remains unknown. It is not obvious that a simple account of changes in the income of charities in this period gives an adequate indication of the evolution of social attitudes towards philanthropic action. In addition to voluntaristic charity, much financial and other support appears to have been exchanged freely and informally through local kinship or neighbourhood networks. The diversity of these private forms of resistance to or compensation for social risks, and their enduring nature throughout the period 1870 to 1939, must challenge any simple assertions about transition from private to public welfare.

Second, the locus of both finance and administration in social welfare did not shift

easily or consistently from the locality to the centre. Neighbourhood and kinship networks remained, of necessity, attached to the locality, since they could only be maintained and reinforced by regular and repeated social contact, and most charities continued to be localised in terms of both their donors and their beneficiaries. The formal involvement of the state in the payment of old age pensions is a clear example of increasing centralisation, but public provision of elementary education remained a local financial and administrative responsibility, and the enduring significance of the poor law (and subsequently of public assistance) ensured that the centralising momentum of the national insurance idea would never completely dominate locally-managed means-tested poverty relief payments before the Second World War.

Third, the redistributive intent and performance of any particular welfare structure was not a function of its location on the public/private axis. Public involvement in social welfare ranged from the solidaristic poor law, in which benefit was related to citizenship and need, contribution to ability to pay, to the largely contractual but participatory national insurance scheme, and the non-participatory and almost wholly contractual edifice of employers' liability insurance. Private strategies to counter social risks could be completely individualistic (personal savings) or mainly contractual (medical insurance) or partly solidaristic (friendly societies or trade unions) or mainly solidaristic (charitable support for voluntary hospitals or local self-help networks).

Taking these three points together shows that in Britain between 1870 and 1939 there was no simple transition from private to public social welfare provision, nor from 'individualism' to 'collectivism', nor even from solidaristic to contractual insurance. This study of the way individuals and society responded to social risks can not, of course, reveal how the majority of working people felt about or

reacted to the social welfare innovations of the period,⁶² nor what the hopes and fears of politicians and policy-makers were, nor why policy and practice changed in the manner and at the time it did. But by emphasising the complex nature of popular responses to social risks this paper directly and deliberately challenges paradigmatic historical accounts of the rise of the British welfare state.

⁶². For differing views on this see H. Pelling, 'The working class and the origins of the welfare state' in his Popular Politics and Society in Late Victorian Britain (London, 2nd ed., 1979), pp. 1-18; P. Thane, 'The working class and state welfare in Britain, 1880-1914' Historical Journal 27 (1984), pp. 877-900.

