Beveridge, Bevan and institutional change in the UK welfare state

Abstract

This paper explores the changes to social security and health proposed in the Beveridge Report through the lens of the framework proposed by Mahoney and Thelen for exploring the relationship between political and institutional contexts, change-agents, and types of institutional change. We find that, in terms of social security, the Beveridge Report led to 'layering' in that it both built on an inherited legacy of institutions from the earlier Liberal Reforms. Although Beveridge assumed the existing of a national health service for his social security plans to work, he did not specify what form such a service could take. Bevan had the advantage of being a Minister of Health with a large government majority, but had to deal with both internal (in Cabinet) and external (primarily from the medical profession) attempts to veto his reforms. Bevan's changes to healthcare have to be seen in that context, as well as in relation to his own pragmatism, in converting the wartime Emergency Medical Service into the National Health Service. By utilising the full Mahoney and Thelen framework in two cases that were near-contemporary with one another, but when contrasted with one another, we show the potential of the framework in cross-case analysis in illuminating the relationship between political and institutional context, change-agents, the type of change that results.

Introduction

The Beveridge Report of 1942 (Beveridge, 1942) is often regarded as the 'blueprint' of the British welfare state, which still casts a long shadow over social policy eighty years after its publication (eg Harris 1997; Timmins 2017; see Introduction to SI).

According to Timmins (2017: 451-2), the main structure and many of the principles of the welfare legislation of 1945–8 were recognizably those which Beveridge had laid down in 1942; and both in Britain and abroad he was increasingly viewed as the 'Father of the Welfare State' and as the presiding genius of modern social policy. Moreover, the Report 'contains almost all the key arguments that have raged about the welfare state since its publication' (Timmins 2017: 50).

This article compares the responses to Beveridge's Giants of Want and Disease with reference to the framework of institutional change proposed by Mahoney and Thelen (2010). This framework is well cited (around 2400 citations: Google Scholar), but has been subject to critique (van der Heijden and Kuhlmann 2017). Moreover, while elements of it, namely the

types of institutional change have been incorporated into several accounts of policy change (eg Beland 2007), it has rarely full used in full (van der Heijden and Kuhlmann 2017). Indeed, its presentation in Peters (2012, pp. 80-82) follows exactly this approach, with the four types of institutional change only being presented.

Moreover, while most studies have examined policy change (eg Beland 2007), we explore policy formulation and implementation for two contrasting sectors. The Giant of Want was central to the Beveridge Report, and was to be slain through its fairly detailed elements of social security. However, the Giant of Disease was hardly mentioned in the Report, but 'Assumption B' of a 'comprehensive health service' was followed by a very different path of formulation and implementation with different veto players. Another major contrast was that while there was a high degree of continuity between the Coalition and Labour governments for social security, there were marked differences for health policy. Finally, while Beveridge put together his Report in 1942, he was an 'outsider' in terms of policymaking itself, and so faced considerable potential veto-power in the political process, whereas Bevan, who was largely responsible for the plan for the eventual National Health Service (NHS), both formulated and implemented the introduction of his plans, but faced considerable institutional veto-power from external interest groups – especially the medical profession. These contrasts set up two fascinating cases that are well-known, but can be illuminated further by a full application of the Mahoney and Thelen framework. How did the political and institutional contexts interact with the actions of the two change-agents (Beveridge and Bevan)? What kinds of change to welfare institutions resulted?

The next section introduces the framework of gradual institutional change (Mahoney and Thelen 2010). This is followed by two sections which apply the framework to the Giants of Want and Disease, and then by a Discussion and a Conclusion.

Institutional Change

A common criticism of historical-institutionalist accounts of policymaking is there lack of ability to explain policy change (Peters, 2012, for example). The importance of the Mahoney and Thelen framework is that it aims to explicitly address this challenge, as well as presenting a typology of different types of change, and their likelihood of occurring depending on the political context, and the type of what they call 'change-agents' which are available.

This section sets out the Mahoney and Thelen framework from their book 'Explaining Institutional Change', in which chapter one provides probably the fullest account of it. Within chapter one, the section 'Patterns of Institutional Change' outlines four different modes of institutional change, they examine three key causal connections, shown in table 1 below (based on Mahoney and Thelen, table 1.4, page 28)

Table 1 – Combinations of political and institutional contexts, and type of change and change-agent

		Characteristics of Targeted Institution	
		Low institutional discretion in interpretation/enforcement	**High institutional discretion in interpretation/enforcement**
Characteristics of the Political Context	**Strong Veto Possibilities**	Subversives (layering)	Symbionts (drift)
	Weak Veto Possibilities	Insurrectionists (displacement)	Opportunists (conversion)

This 2x2 matrix is formed by the dimensions of characteristics of the political context (which is formulated in terms of veto possibilities), and characteristics of the targeted institution (considered in terms of discretion in interpretation/ enforcement). In each context, a different change-agent is more likely to be successful, along with a specified type of institutional change. They specify four types of institutional change as being possible:

- Displacement - which is the removal of existing rules and the introduction of new ones;

- Layering: the introduction of new rules on top of or alongside existing ones;
- Drift: the changed impact of existing rules due to shifts in the environment; and
- Conversion: the changed enactment of existing rules due to their strategic redeployment

Mahoney and Thelen claim that differences in the character of existing institutional rules as well as in the prevailing political context affect the likelihood of specific types of change. They set out two broad questions. First, does the political context afford defenders of the status quo strong or weak veto possibilities, which can derive either from especially powerful veto *players* or from numerous institutional veto *points*? Second, does the targeted institution afford actors opportunities for exercising discretion in interpretation or enforcement?

The type of institutional change is linked back to the political and institutional context, as well as to the likely type of change-agent in those contexts. Conversion normally occurs when rules are ambiguous enough to permit different (often starkly contrasting) interpretations. Drift can occur when a gap opens up between rules and enforcement (in this case, often a gap due to neglect). Administrative capacities may be especially important for conversion and drift, because weakness on these fronts can create strategic openings for those who oppose existing rules. By contrast, the other two modes of change, layering and displacement, do not rely on exploiting ambiguities in the rules themselves. These outcomes are likely strategies for change agents who realize that transformation cannot occur by taking advantage of a disjuncture between rules and enforcement. With layering, the old institution remains in place but is amended through the introduction of new rules. With displacement, the old institution is simply replaced – outright and abruptly or gradually over time. Either way, change occurs in a manner that does not entail shifting the interpretation or enforcement of rules that remain intact. The combination of the characteristics the targeted institution and political context leads to logic for both the type of change and change-agent. For example,

they argued that low level of discretion in interpretation/ enforcement and strong veto possibilities are associated with layering by subversives.

Mahoney and Thelen defined actors or 'basic change agents' by asking two basic questions: whether the actor aimed to preserve the existing institutional rules, and if they abided by the institutional rules? This gave four types: insurrectionaries, symbionts (either parasitic or mutualistic), subversives, and opportunists. *Insurrectionaries* consciously seek to eliminate existing institutions or rules, and they do so by actively and visibly mobilizing against them. *Symbionts* come in two varieties – parasitic and mutualistic – and in both instances rely (and thrive) on institutions not of their own making. *Subversives* are actors who seek to displace an institution, but in pursuing this goal they do not themselves break the rules of the institution. They instead effectively disguise the extent of their preference for institutional change by following institutional expectations and working within the system. (p.25). Finally, *opportunists* are actors who have ambiguous preferences about institutional continuity. They do not actively seek to preserve institutions. However, because opposing the institutional status quo is costly, they also do not try to change the rules. Opportunists instead exploit whatever possibilities exist within the prevailing system to achieve their ends (p.26).

In short, Mahoney and Thelen pulled together aspects of context and types of actors to generate some general propositions concerning the kinds of environments in which different agents are likely to emerge and thrive. First, *insurrectionaries* can emerge in any setting, but they are more likely to flourish in environments characterized by low discretion and weak veto possibilities. Second, *symbionts* of the parasitic variety are the mirror image of this, thriving in environments characterized by strong veto possibilities and high enforcement discretion. Third, *subversives* can be expected to emerge and thrive in contexts in which the existence of strong veto possibilities and few rule interpretation and enactment opportunities makes it difficult for opposition actors to openly break or even bend the rules of an

institution. Finally, *opportunists* tend to thrive in settings where there is a great deal of discretion in how institutions are enacted and there are few veto players or points to prevent actual institutional change.

Method

The paper now explores the two cases – those of Want and Disease – using the framework outlined above (see Author Refs, this Issue). Each of the two areas has an extensive literature attached to them, which we compiled by first examining histories of the UK welfare state (for example, Harris, 2004; Lowe, 2004), and then following-up references. Any final gaps were filled through a search of the usual bibliographical databases. Following broadly the logic suggested by Archer (1995) in exploring the analysis of change, each section first considers the political and institutional context into which the welfare change proposals appeared, followed by an account of how Beveridge (Want) and Bevan (Disease) acted in those contexts in order to attempt change. Finally, we consider the result of the interactions between the context and the change agents to arrive at the type of institutional change that resulted. We present the cases in their entirety first, before comparing the findings, and making clear the contribution of the paper in terms of considering the Beveridge Report and reforms to social security and health, as well as considering the implications for the Mahoney and Thelen framework.

The Beveridge Report and change in social security and health care

Although the institutional changes to social security and health occur at different times – from 1942 for social security, but primarily from 1945 onwards for health, much of the impetus for change for both areas starts with the publication of the Beveridge Report in 1942.

It is beyond the scope of this paper to explore the extensive history of Sir William Beveridge prior to 1942 (see Author Refs, this SI). However, it is worth starting with the idea that, by 1942, Beveridge had achieved a remarkable amount in his life, but was not being included the British war effort or plans for reconstruction. He engaged in an extensive period of lobbying government, and only then (and perhaps to avoid further irritation) was given the brief to consider the role of social insurance post-war.

Beveridge's committee was set up in 1941 as a result of TUC pressure to examine 'social insurance and allied services', which was regarded as a 'tidying up' exercise with limited and harmless terms of reference. However, its chair, Sir William Beveridge, used the opportunity to consider the future of the welfare state in the UK, producing a report that used visionary language to specify what was necessary to defeat the 'Giant' of Want through a flat-rate social insurance scheme, which was underpinned by means-tested Assistance (Harris, 2004). However, for Want to be slayed, Beveridge claimed that it was also necessary for establish a free national health service, policies of full employment, and family allowances.

The reforms to social security

The first stage of analysis is to consider the political and institutional context into which Beveridge had to introduce his proposals. The British system of government is one of single-party majorities and first-past-the-post elections. With a majority in the House of Commons, this means a political party is able, provided it is able to mobilise its own MPs, to exert its legislative will even if its policies are strong opposed by all opposition groups. In wartime, however, a coalition government was in place with senior representation from both Conservative and Labour MPs, requiring a more collective approach, and one that was arguably more difficult to negotiate to achieve significant change, especially given the

uncertainties of the ongoing war. Equally, although the government was mandated to fight the war, it did not have such a mandate for post-war welfare policy.

In the context of social security, there was an additional barrier. Although Beveridge was writing his Report *for* the government, he was not *in* the government. He was briefly (1944-1945) a Liberal MP in the House of Commons, and then entered the House of Lords. He spoke in many of the Debates on the legislation implementing his proposals, but had no major impact on them (eg Harris 1997).

As such, there were two main sources of political veto-power in relation to social security – the structure of wartime government, and Beveridge's position as external to policy processes themselves. Institutionally, the social security system confronting Beveridge was fragmented. An incremental process of policymaking had occurred over the previous thirty years which offered uneven governmental cover, and which was often supplemented by private or not-for-profit insurance, sold by fleets of door-to-door agents who both sold and collected premiums. However, many of those agents were away in the armed forces in the early 1940s, and so scope for the kind of lobbying they had carried out thirty years earlier against Lloyd George's proposals were limited (Harris, 2004). As well as being weakened in terms of the everyday business of premium collection and sales, insurance representative bodies were also substantially weakened in terms of their access to government by the war. There was an opportunity, if Beveridge were to achieve agreement during wartime, to put in place greater change to the social security system than might be possible after it.

As such, Beveridge faced considerable potential political veto-power against any changes he proposed unless he was able to achieve agreement inside the political process. However, institutionally the scope for change was perhaps wider than first appeared because of the fragmentation of insurance interests during the war.

Beveridge as change-agent

Beveridge was a liberal. His views had changed since World War 1 (see Harris 1997; Author Reference this issue), and he had moved from viewing unemployment as a simple matter of a lack of labour market efficiency to one where demand-deficiency in Keynes's framework could also be a significant problem. He was not seeking to uproot the British social security system, but to build on it, and combined with reforms in other areas of social and public policy, to build a new vision for greater societal efficiency in which self-reliance could be combined with greater collectivism through a series of institutional extensions and compromises.

Beveridge's proposals for social security comprised of a comprehensive system of social insurance (linking back to his brief), based on a single level of contribution and benefit paid at subsistence levels. In addition, he made extensive proposals for eligibility for such a scheme, and for how social assistance would work alongside it.

His proposals were based on three principles. First, building on the experience of the past, but asking that the experience of war allowed for a 'clear field' in terms of looking afresh at old problems. Second, that social security be seen as part of a process of comprehensive social planning to defeat the 'Giants' blocking the path to civilised society - Want, Ignorance, Squalor, Idleness, and Disease. Although his plan was mostly concerned with Want (as well as Idleness), his assumptions (outlined above) presented his work in a visionary language that was to be important in getting media attention, public agreement, and so putting pressure on the government to accept them. Third, Beveridge wanted to achieve 'co-operation' between voluntary and public action, as well as between the individual and the state. This was embodied in his plan being based around flat-rate insurance paid at subsistence levels, and

which aimed to allow a degree of independence, but also to encourage thrift and saving from those who wanted to be sure of greater levels of support (Beveridge, 1942).

Beveridge's plan therefore built on the existing systems of social insurance, but extended them considerably as well as requiring a significant extension of government social policy in other areas in order to make them work. Beveridge was not seeking to overturn existing institutions, but to extend their remit, framed within visionary language that sought to locate them in an expanded welfare state.

The second stage of Mahoney and Thelen's framework requires us to consider Beveridge's strategies in trying to overcome any barriers put up against them. The first response was very positive - the Ministry of Information saw potential in Beveridge's plan to raise public morale, and sought to publish the first pages of his report. It sold over a hundred thousand copies, and was circulated to the armed forces as a means of showing what those fighting for the country might return to.

The insurance industry, as outlined above, were in a weakened position during wartime if they attempted to lobby against Beveridge's proposals, but had much to lose from them. However, there were two main factors preventing this. The first was the absence of the door-to-door agents on wartime duties (outlined above). In addition to this, the industry had little time to organize themselves in opposition. After the Report's launch, the industry's representative body attempted to present Beveridge as out-of-touch, claiming he lacked knowledge of working class life. Presenting a very different kind of opposition, the National Federation of Old Age Pensions Associations opposed his pension proposals, arguing that his proposals were too modest and should be both payable at a higher level and a citizen right, rather than being the reward for making contributions to the Fund for the required period (Harris, 2004). As such, although there was strong public interest and support for the

proposals, there were also opposing views outside of Parliament – but with little leverage, at that time, in terms of vetoing Beveridge's plans.

If Beveridge faced reduced institutional veto-power, he still faced significant political barriers. However, the widespread public interest, alongside Beveridge working with the media to popularise his proposals further, put the government in a difficult position. The wartime government responded by submitting the Report to a committee under Sir Thomas Phillips for further scrutiny. The Phillips Committee accepted the need for a comprehensive health service, but were critical about the possibility of maintaining full employment and questioned both the need and viability of offering family allowances, so rejecting two of the three the key assumptions underlying Beveridge's plan. The committee accepted Beveridge's principle of universalism, but rejected the principle of subsistence, flat-rate benefits in his proposals, concerned at the variations in housing costs which would not be addressed as a result (a topic which Beveridge struggled with in his Report, before admitting he could not resolve it).

The Treasury were also concerned about the potential costs of the Plan in the context of a post-war situation where the substantial costs of the War would have to be repaid. The Prime Minister too believed that it was premature to plan for reconstruction, especially for proposals that he believed would require testing in a general election in order to find out their actual level of support.

However, there were also supporters of the Plan in government, especially from Labour MPs. Herbert Morrison argued for the early implementation of the Plan, but found himself frustrated by the Committee on Reconstruction Priorities. Within the Commons, a debate was forced on the Beveridge Plan in February 1943, and the refusal of Minister to commit themselves to its ideas led to Labour and Liberal backbenchers voting against the government. The government responded to this increased pressure by referring Plan to

another committee, this time led by Thomas Sheepshanks. Beveridge himself was not included in these discussions, but he continued to apply pressure from outside of Parliament, capitalising on the wider popularity of his plan and his links to the media to ensure that discussion of it did not leave the public sphere. Beveridge also moved on to produce a second report, this time outside of government, on full employment, as well as being elected to Parliament in October 1944 as an MP.

The government eventually produced a White Paper on social insurance, with Beveridge (during his brief time as an MP), speaking in the debate. However, by this time, and as a result of the Sheepshank committees recommendations, which were more or less accepted, his proposals had undergone a range of significant changes, including pensions being introduced without a compulsory period of contribution beforehand, and the social insurance scheme not following the principle of subsistence in his Report (Glennerster, 2007). Beveridge did lay a path for significant changes to social security to occur, but with the actual proposals making significant change to his original plans.

Social security institutional change

Considering institutional change means considering the extent to which the 'rules' as well as the institutions of social security were different (or the same) as a result of the events outlined above. In terms of the 'rules', Beveridge's plan was designed to work with the 'grain' of the existing system in that it extended social insurance, carefully locating people into 'classes' which would have been familiar at the time. His social insurance plan was contributory (in line with existing public and private schemes) with social insurance conditional on previous contributions. New rules were certainly introduced (and strongly opposed by many parties in the government), but in the face of substantial veto power (in two government committees,

which modified Beveridge's original proposals substantially), and even if Labour broadly accepted the recommendations of the Sheepshanks committee, that resulted in social security being taken in a different direction to Beveridge's original idea - with benefit levels being different, with pensions being introduced early and so on a non-contributory basis, and with the balance between social insurance and social assistance being very different to Beveridge's scheme.

In terms of the institutional change types in Mahoney and Thelen's framework, social security represents more an example of layering, as what was legislated ending up building on established institutions and extending them rather than replacing them outright. Beveridge saw his plans substantially amended, even though at least in outline, they had strong public support. However, as Beveridge's plans were complex, and his visionary presentation of them was perhaps better known than their actual detail, governments could position themselves at conquering a 'Giant', even if they had translated the original plans into a different form by the time of their introduction.

In terms of possible change-agent roles, Beveridge therefore seems to fit with the mutualistic symbiont type, but with his wider vision for social policy change being more subversive. Beveridge sought to preserve the existing institutions rather than completely overturn them, but at the same time saw the need for the wider context of social policy to be substantially changed. Interestingly, Mahoney and Thelen have little to say about mutualistic symbionts except for a short paragraph (Mahoney and Thelen, 2010, p.24) in which they are described as violating the letter of rules in institutions to try and achieve their wider goals. As such, they aim to build new coalitions of support for institutions, modifying them so that they will survive. This seems to be the case with social security – with Beveridge's recommendations being about the expansion of existing institutions and rules, within a distinctively British view of contribution and benefit receipt, and explicitly rejecting overseas approaches which

allowed for differential levels of both. This meant that his recommendations, despite causing the Treasury such consternation in terms of the increased scope of social security, were an extension of pre-war policy rather than seeking to overturn it. However, his wider vision for social policy was somewhat more radical, requiring the conversion of existing structures into something new.

At the same time, Beveridge's wider vision about welfare, embodied in his visionary language and this assumptions of what was necessary to make the social security changes possible, appears more significant, and so is closer to, in Mahoney and Thelen's terms, conversion. The main structure of the new welfare state, and many of the principles put into place in the late 1940s were heavily influenced by Beveridge's 1942 proposals - he had provided a 'frame' within which the post-war reconstruction had to fit (see also Author Reference, this SI). It is with this insight that the paper turns to its second case study – that of healthcare.

Health Care

In wartime, healthcare faced the same, coalition-government-based context as social security. It proved difficult to come to a consensus view of what a national health service would look like, how comprehensive it would be, and whether it would be free for the public to use.

The healthcare institutional and political contexts

The problems of the fragmented health care system (voluntary hospitals, local authority hospitals and services, general practitioner services provided through National Health Insurance) had been clear before the Second World War (Powell 1997, Webster 1988). There

was some slow and limited progress on reform before the Beveridge Report and before the Second World War. In December 1936, the Chief Medical Officer was asked to prepare proposals for the provision of specialist services, and four office conferences were held in 1938 to discuss 'Development of the Health Services' (Webster 1988: 21).

It is important to note one very important element of post-war health policy resulted from the 'external shock' of war. In anticipation of large numbers of civilian casualties due to bombing, the Emergency Hospital Service (EHS) was set up. According to Webster (1988: 22) 'it was said at the time that Hitler and the Ministry between them had accomplished in a few months what might have taken the British Hospitals Association [representing voluntary hospitals] twenty years to bring about.' He continued that the EHS, created as a temporary expedient, 'marked a secular shift towards a nationally planned and rationalised hospital service'. He cites the 1944 White Paper (below) that this wartime experiment had translated 'a collection of individual hospitals into something of a hospital system'.

In 1941, so before the Beveridge Report, The Minister of Health, Ernest Brown made a statement on post-war hospital policy in the House of Commons (Hansard, Vol 374, cols 116-120, 9 October 1941). Although the statement was rather vague, it seemed that the 'comprehensive hospital service' would not to be free at the point of use.

Beveridge presented the case for 'a' national health service being necessary in 1942, but did not give any specific recommendations or detail on how one would be organized. Beveridge's 'Assumption B' pointed to comprehensive health and rehabilitation services for prevention and cure of disease and restoration of capacity for work, available to all members of the community' (para 301). He stressed that but one hundred per cent of the population must be covered [ie universal] (para 431). He left open the 'minor question' of hotel expenses" for hospitals (para 434), but was clear that every citizen will be able to obtain whatever treatment is required without a treatment charge (para 437). Webster (1988: 35) argued that Beveridge

was voicing aspirations of the public at large regarding a comprehensive health service. The Assumption 'emerged as a commitment that would be very difficult for any administration not to honour', and Beveridge provided the 'final catalyst' to translate earlier departmental thinking into a positive set of proposals (Webster 1988: 36). Despite the 'cool reception' from the Treasury for Beveridge's Report (p. 38), the Committee on Reconstruction Priorities accepted the Beveridge line on health. The War Cabinet agreed that the government spokespersons would announce acceptance of the principle of a comprehensive service, but this might take 'many years' and that would not exclude the continuation of voluntary hospitals or private practice (p. 39).

In the Parliamentary Debate on the Beveridge Report (16 February 1943), Sir John Anderson, Lord President of the Council, stated that the government accepted Beveridge's three Assumptions. In November 1943, Henry Willink (Conservative) replaced Ernest Brown (National Liberal) as Minister of Health. After the best part of a year of consultations, chiefly with the medical profession, the voluntary hospitals and the local authorities (Timmins 2017: 111), the White Paper 'A National Health Service' appeared in February 1944. Webster (1988: 55) noted that reference to Beveridge was minimal in the final text, and that while 'free' and 'comprehensive' were the keynotes of the new service, yet both were subject to significant reservations. Similarly, Timmins (2017) stated that its precise form remained far from clear. The immediate reception of the White Paper was positive, and it received a 'reasonably warm, but by no means unanimous response' in the Parliamentary Debate (Webster 1988: 57-59; Hansard Vol 398, cols 427-518, 535-633 16-17 March 1944; cf Pater 1981). It was further whittled down with more compromises to the medical profession (Timmins 2017; Webster 1988).

This 'infinite regress' (Webster 1988) meant that, by the end of the war – by which time the plan for social security was more or less in place, what would happen to healthcare was far

less clear. The landslide election victory by Labour in 1945 meant that the government had a strong hand in putting forward a more radical plan with little ability from opposition parties to veto them.

Bevan as change-agent

Aneurin Bevan was in some ways a surprise appointment as Minister of Health. The former rebel and left-winger, he was the youngest Cabinet Member, and was not close to the Socialist Medical Association, which was regarded as being at the core of Labour health policy. While Ministry civil servants advised caution, pointing out the advantages of staying largely with the Coalition White Paper, Bevan rapidly decided on the radical solution of nationalising the hospitals.

At the macro level the political context was the same for health care and social security in the sense that the reforms needed to navigate the Parliamentary process. However, Bevan was a Labour Minister of Health in a government with a large parliamentary majority. He was determined to introduce his scheme rather than adapt Willink's scheme, as some of his civil servants suggested (Pater 1981; Webster 1988). Bevan's proposal were also against the Labour policy of municipalisation, which led to a significant debate in Cabinet with Herbert Morrison, former leader of the powerful London County Council and seen as the defender of local authorities. Indeed, many commentators present the debate in Cabinet as representing Bevan's biggest battle (Klein, 2013).

Morrison argued that Bevan's departure from Labour party policy, which supported a municipal health service, based on the local authorities, would damage local government and local democracy. However, PM Clement Attlee summed up in favour of Bevan (Pater 1981; Webster 1988; Powell 1997).

There was some opposition from Labour MPs in the Parliamentary Debates, including members of the Socialist Medical Association, who stressed Labour party policy of a health service based on local authorities. The Conservatives wished to retain the voluntary hospitals, and voted against Bevan's NHS on the Second and (very unusually) Third Reading of the Bill. However, unlike social security, the most significant veto power came from outside the political system in the form of opposition from the British Medical Association.

Bevan judged that Willink had 'run away from so many vested interests that in the end he had no scheme at all' (Timmins 2017: 113). In the Debate on the NHS Bill (Hansard, Third Reading, 26 July), Labour backbencher Fred Messer recalled that Willink realised that there was an enormous problem to face in getting anything like a national service, because large numbers of interests were affected, including the local authorities, various sections of the medical profession, large numbers of voluntary agencies and, in addition, the modern hospitals (col 426).

In the Second Reading of the NHS Bill, Bevan insisted that 'I made up my mind that I was not going to permit any sectional or vested interests to stand in the way of providing this very valuable service for the British people' (col 46). In the Debate on the Third Reading, Mrs. Ridealgh (Labour, col 435) argued that 'the Opposition do not want a national health service. They want a vested interests health scheme. I am glad that our Minister will not accept it', Sir Henry Morris-Jones (col 450) argued that no real negotiations have taken place with the interests concerned under this Bill (doctors, dentists and pharmaceutical chemists). He continued that 'I am sorry that the right hon. Gentleman has not seen fit to have such negotiations, because the Socialist Government of Australia, the Government of South Africa and the Socialist Government of New Zealand have all done this.'

Bevan's major challenge however, was not from the political context, but from the institutional one. As Pater (1981: 139) put it, over some 20 months from the time when the

Bill became law in December 1946 until the 'Appointed Day of 5 July 1948, 'the opposition to it was stimulated and maintained almost exclusively by the doctors.' While the local authorities and voluntary hospitals felt bound to accept Parliament's verdict, the BMA did not.

Webster (1988: 107) discusses 'inevitable conflict' and 'acrimonious controversy' with the medical profession. Having been relatively successful in negotiating with previous Ministers of Health (above), the BMA expected to exact major concessions from Bevan (eg continuation of private practice; medical representation on boards: see eg Powell 1997). At the 1946 BMA meeting, Bevan was denounced as a 'dictator' and it was decided to hold a plebiscite to determine whether the profession would co-operate in framing the regulations for the new service. This resulted in 54% voting against discussions on the regulations. However, Bevan carried out a 'divide and rule' strategy, and found discussions with the Royal Colleges more amenable. Only a few months before the 'Appointed Day' of 5 July 1948, a second BMA plebiscite of March 1948 confirmed a hardening of attitudes, with large majorities against the Act and in favour of boycotting the service. It seems that the deadlock was broken by Lord Moran of the Royal College of Physicians calling for an Amendment precluding whole-time salaried service, which Bevan delivered. In addition, he allowed generous financial rewards to the powerful hospital consultants, leading to the phrase that he 'stuffed their mouths with gold'. Moreover, he pursued a 'game theory' strategy with GPs, knowing that those GPs who did not sign up for the new service would be left with very few remaining paying patients. In short, by a combination of 'iron fist' (asserting Parliamentary sovereignty and holding his nerve) and 'velvet glove' (concessions to the medical profession), Bevan avoided the veto deadlock encountered by previous Ministers of Health.

Healthcare Institutional change

In Mahoney and Thelen's terms, health care represents a mix of d*isplacement* (existing rules are replaced by new ones) and *layering* (new rules are attached to existing ones, involving amendments, revisions, or additions to existing rules).

Bevan's major change, the nationalisation of the hospitals, can be considered as both layering and displacement. Viewed in the short term, this can be seen as layering as it essentially proposed the continuation of the wartime EHS, which saw the hospitals managed on a national basis. However, in the longer term, it can be regarded as displacement as it radically changed the Conservative vision of preserving the Voluntary Hospitals and the Labour plan of gradually bringing hospitals under local authority control through a process of 'creeping municipalisation'.

Bevan's plan can also be regarded as closer to displacement when compared with the Coalition government's White Paper 'A National Health Service' (Ministry of Health 1944). The most significant 'rule change' was the clear commitments to a free and universal service, which were both heavily qualified under previous schemes (Webster 1988; Powell 1997).

However, there were also clear signs of layering. The 'Tri-partite' structure was clearly built on the existing structures of hospitals, primary care and local authority services, and the ability to nationalise hospitals clearly owes a substantial debt to the wartime experience of the Emergency Medical Scheme. Bevan did face considerable veto power from the medical profession (which fits with layering), but in a context where significant change (because of the war) had already been put in place. Without the war, it is not clear that Bevan could have overcome the veto power he faced and put in place a nationalised hospital system.

Discussion

This application of the Mahoney and Thelen framework above has been fruitful in structuring an account of the contexts, actions and institutional results in relation to significant periods of social security and healthcare policy change in the 1940s. Considering the cases in this way presents a range of comparisons and contrasts that allow us to examine the 'fit' of the framework. Did institutional change occur in the way that Mahoney and Thelen suggest it should?

A first point is that, any account of institutional change has to narrate the events in some kind of order. Mahoney and Thelen are not clear about how this might be best done, and we have attempted here to work through context, action and result in a logical order that we hope is true to the framework, while at the same time accepting that the account could have been given differently. However, by presenting context (political and institutional) first, this allowed us to show the constraints and opportunities facing Beveridge and Bevan, before going on to narrate show they attempted to achieve change, followed by the results.

The Mahoney and Thelen framework is generally used to categorise types of institutional change, but here we have tried to link to processes of policy formulation and implementation as well. This has highlighted the importance of the political institutional structure in the UK, and of the very different situations facing Beveridge and Bevan in relation to it. We also need a more nuanced view of 'veto' – Beveridge did not find his proposals 'vetoed', but instead referred to complex institutional processes over which he had no control. There are also significant differences in terms of the institutional contexts Beveridge and Bevan inherited – for Beveridge, with much less veto-power from the insurance lobby than Lloyd-George faced thirty years earlier, but with Bevan facing a much more formidable group.

There is also a significant contrast in the situation *after* the institutional changes narrated here. The social security system depended upon a network of benefits offices and systems that were largely 'within' government, and although individual offices had some 'street-level'

discretion, it was a system over which the government of the day could exert significant control in terms of setting rules and ensuring they were followed. In healthcare, the government might have put in place its National Health Service, but quickly found out that it had very little control over its day-to-day workings, most of which fell upon the medical profession to implement. This is a salutary lesson which governments still have not learned 80 years later – it is one thing to get legislation enacted in Parliament to put in place institutional change in the NHS, but quite another to enact it in the service. Veto-power lies not only in policy formulation and legislation, but also in implementation.

Within Mahoney and Thelen's framework, we might say that Beveridge faced a situation of high political veto (as an 'outsider') but weaker institutional veto, because the insurance industry was not in a position to mobilise against his proposals in the same way as they had done thirty years before. This combination should lead to Beveridge pursuing a 'subversive' strategy, and to 'laying' as the likely type of institutional change. Equally, Bevan faced weak political veto (because of Labour's significant majority), but strong institutional veto (because of the power of the medical profession), and this logic links the logic of 'opportunist' change-agent behaviour and to 'conversion' as the likely institutional change. Was this the case?

It was not possible for Beveridge to work within the existing political system as, after he had submitted his Report, he had no other role in government (except for his brief time as an MP). He therefore could not subvert within the system, but did, as we saw, manage to exert influence through his public profile, putting indirect pressure on those within government to act. Beveridge's actions also have significant aspects of the 'symbiont' type of change-agent however, as he was not seeking to over-turn the existing social security system (as a subversive would be), but instead to modify it to work better. He therefore fits with the notion of a mutualistic (as opposed to parasitic) symbiont in aiming to improve the 'spirit' of the

system, and seeking to ‘sure up’ social security rather than replace it with something else. The end result, the ‘layering’ of the new social security roles on the original template of those thirty years before, does seem a good fit with theory.

Bevan, were he an opportunist, would be ambiguous about the present state of the institution as well as about whether or not he was prepared to follow rules in achieving institutional change. Despite his reputation, perhaps as more of an insurrectionary (because of his strong public language and battle with the doctors), this is a reasonable positioning of Bevan. Bevan followed rules where it suited him (such as not divulging his plans until they had reached Parliament), but was also pragmatic enough to realise that he had offer concessions to the consultants (the right to private practice) and GPs (the right to remain as independent contractors). Labour’s significant Parliamentary majority gave him the ability to legislate, and his pragmatism in negotiation with the medical profession meant his NHS could launch on time – even if, he had remarkably little control over what it subsequently did.

Equally, there are strong grounds for arguing that the creation of the NHS represented an institutional change of conversion rather than displacement of existing healthcare institutions. Compared to the pre-war health system it was certainly a conversion, but compared to the situation in 1945, with the EHS in place, Bevan was converting the largely-nationalised wartime health system into a peacetime one – a very different process.

Conclusion

The paper finds that Beveridge’s original vision faced significant internal veto power but relatively few challenges in terms of interpretation and enforcement, resulting in his plan being significantly modified in implementation despite its huge public popularity. Bevan, in putting in his plan for The National Health Service, in contrast, faced relatively little governmental opposition but substantial medical challenge. However, because arguably the

most controversial element of the proposals, the nationalisation of hospitals, had been put in place during wartime, Bevan's proposals, were therefore closest to conversion in form, and even then, subject to substantial gaps in implementation because of the need for doctors to comply with its proposals. Equally, whereas Beveridge depended on others to implement his plans, Bevan was able to see his NHS proposals through himself, giving them a strong advocate in government.

Beveridge appears to be a mix between a subversive and mutualistic symbiont, layering his changes to social security on top of existing structures. This is a reasonable fit within the Mahoney and Thelen framework, but there remain complex issues around the extent of change required to claim displacement (the most radical form of change), and Beveridge's role as writer of a government Report, but not within the government, is also difficult to fit within it.

Bevan appears to represent, in contrast, a change-agent who in Mahoney and Thelen's terms is a mix of opportunist (in his deal-making with the medical profession) and insurrectionist (in his proposals, which were radical compared to the health system pre-war, but less so compared to the situation during the war).

As such, the Mahoney and Thelen framework appears to work fairly well in the cases presented here. However, there are at least two issues that require further thought. The first is the role of ideas. The Mahoney and Thelen framework appears to present contextual factors in an objective way, when different actors will interpret them in different ways – and this will be especially important when change-agents are considering their strategies. As Blyth (2003) famously remarked – structures do not come with instruction sheets. Considering the relationship between context and agency-agency in a strategic way – which we have attempted to do above – is clearly important so that the importance of ideas (such as Beveridge's liberalism) are not overlooked.

Second, a degree of interpretation is involved in assessing the extent of change – and so the institutional result of policy change. When can we say that displacement as opposed to layering has taken place? This issue may not be easily resolvable, but it is important to note that interpretation is necessary on the part of the analyst, and to try and justify the type of change institutions have experienced in those terms.

The use of the framework in the way proposed here presents a significant opportunity for further, detailed case-based work, especially in comparative frameworks. We hope this others might take the opportunity to use the full framework, involving context and change-agents, rather than drawing on types of institutional change only. In terms of social policy more generally, there is arguably a tendency toward 'layering' being the most common type of policy change. It would be fascinating to explore other cases comparatively, within the Mahoney and Thelen framework, to consider why this might be the case.

More generally, the framework also raises again the key point that we should not confuse radical policy intentions with radical policy implementations – especially where there are strong interest groups who governments depend upon to implement their proposals. However, if there has been a decline in power of professional groups in welfare, as stronger management and policy delivery has come to the fore, this raises the question of whether policymaking is increasingly mostly a political process, focusing attention on the importance of getting social policy formulation and legislation right – a challenge which governments often appear to struggle with.

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