Overthrowing the market in health care: the achievements of the early National Health Service

College lecture

Recent upheavals in the organisation and management of health care in Britain are defended on the grounds that they constitute a substantial improvement in services to patients. Inevitably, such assertions are associated with lamentations about flaws in the National Health Service (NHS) in its previous incarnation. Advocacy of the new order tends to be associated with denigration of the old. This drift of argument connects with the more generalised belief that the architects of the welfare state were fundamentally misguided. At an extreme, these pioneers are dismissed as woolly-minded idealists, or 'New Jerusalemites', whose zeal for squandering public resources on the new welfare state effectively undermined the British economy [1,2]. The early National Health Service under its founder, Aneurin Bevan, is regarded as the most conspicuous example of wasteful expenditure on welfare. Its centralised and command-led system of administration is regarded as a fundamental misconception which has at last been corrected by the application of market principles. In the interests of its own conception of progress, the present administration has set about eliminating many of the characteristics of the health service established by Bevan. This record has also come under criticism from other quarters. Ever since the emergence of the New Right, it has been argued that Britain made a fundamental mistake by not adopting the insurance-based systems of health care prevalent in America and many parts of Europe [3–5]. It is suggested that the NHS departed from the best indigenous traditions of health care, for instance by nationalising the voluntary hospitals. Advocates of the present arrangements pretend that the market system in some way recaptures the spirit of emulating our Victorian forefathers, epitomised especially in the old voluntary hospital system.

Crisis in the voluntary hospitals

At first sight, the voluntary hospitals, which dominated acute care in Britain, appear to have been remarkably buoyant institutions. Never robust in their finances, the voluntary hospitals were subjected to big strains during World War I and the subsequent Depression. Nevertheless, the voluntary hospitals survived and were collectively able to maintain an appearance of solvency. Some sank into difficulties, others were able to rebuild or sustain surpluses. Recent investigators have understandably criticised the tendency of past historians of the NHS to neglect the positive achievements of the voluntary hospitals. Prochaska [6] rightly points out that within the British voluntary hospitals it was possible to find standards of care matching the best in the world.

Nevertheless, it is difficult to escape the impression that the voluntary hospitals were living on borrowed time. Pessimism about the voluntary system is not merely a construct of enthusiasts for the NHS. During the 1990s, the leadership of the voluntary hospitals, especially in London, became deeply worried about the future. Although they were successful in maintaining the hospitals from year to year, the managers of the voluntary hospitals were acutely aware that their resources were insufficient to meet their wider obligations. Indeed, on the basis of existing trends, it was increasingly evident that they would be unable to keep up with the rising costs connected with rebuilding, medical innovation, or paying their staff. In real terms, the costs of maintaining acute beds approximately doubled during the interwar period, and this escalation in costs looked set to continue. There was no sign that the income of the voluntary hospitals would be able to match this pace of rising costs. Objective analysis suggested a bleak future unless the voluntary hospitals could substantially increase their resources.

The problems of the voluntary hospitals went beyond lack of resources. The spirit of local pride which inspired the creation of the voluntary hospitals tended to create circumstances in which they were working in competition. The situation approximated to a market, with only loose liaison arrangements supervised by organisations such as the King Edward’s Hospital Fund for London (King’s Fund) or the British Hospitals Association (BHA), both of which attempted to introduce some element of order and prevent complete anarchy within the medical market place. However, their interventions were of only marginal significance.

There is every indication that the competitive system helped to impair the efficiency and viability of the

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voluntary hospitals. Even before 1900, reports on the gathering crisis facing the hospitals called for greater cooperation in the interests of efficiency. There was unanimity in these criticisms. Typically, an authoritative and impartial review, Political and Economic Planning [7], complained about ‘isolationism’, ‘administrative overlapping and waste’ within the voluntary hospitals. Professor Henry Cohen (later Lord Cohen of Birkenhead) [8] pointed out that ‘parochial patriotism’ was driving hospitals into bankruptcy, without necessarily improving the quality of care.

‘All over the country there grew up small hospitals, over-equipped with apparatus, which in many cases no member of the staff was qualified to use and often undertaking treatment, especially surgical, with the staff lacking the necessary training, experience and qualifications.’

The vulnerability of the voluntary system was exposed by the increasing investment by local government in hospitals performing functions traditionally within the province of the voluntary sector. It is often not appreciated that by 1939 local authorities were not only administering hospitals for infectious diseases and long-stay patients, but that they were also providing about the same number of acute beds as the voluntary hospitals. The best of the local authority hospitals, such as the Hammersmith Hospital founded by the London County Council (LCC), or the Central Middlesex Hospital maintained by the Middlesex County Council, gained reputations as centres of excellence for treatment and research. Within the LCC area there were 146 voluntary hospitals operating largely independently of one another, shadowed by 69 hospitals maintained by the LCC, operating as an integrated system. This represented an instructive example of the parallel existence of market and non-market hospital systems. Taking London as an example, it became increasingly evident that the market failed to prove its superiority, or even to guarantee the viability of the voluntary hospitals, while the most vulnerable of all the voluntary hospitals were the prestigious undergraduate teaching hospitals.

With respect to their big financial problems, the voluntary hospitals had not completely run out of ingenuity in their search for additional resources. Direct charges on patients or payments on their behalf by contributory funds or local authorities assumed ever greater importance; by 1939 these contributions accounted for more than 40% of the income of voluntary hospitals in London. Following the success of hospitals savings schemes for the working classes, preparations were made for the introduction of contributory schemes for the middle classes. However, this initiative antagonised general practitioners; who saw the contributory schemes as a threat to their incomes. Consequently, these schemes were developed to only a limited extent. An even more abortive proposal emanated from the Duke of Gloucester who, on the model of the King’s Fund, suggested that a new national fund should be established for the benefit of all hospitals [9]. The failure of this royal initiative perhaps demonstrated that the spark of hospital philanthropy was past the point of rekindling.

Regionalisation

In the increasingly desperate struggle for survival, the voluntary hospitals were driven to consider sacrificing some of their cherished independence and consent to a much greater degree of coordination and integration. This goal came to dominate the thinking of planners within the voluntary hospital world during the later 1930s. The slogan for this mission was ‘regionalism’ or ‘regionalisation’. It had been realised since 1918 that the hospital system would be increasingly impaired unless a much greater element of integration was introduced. This conclusion had been implicit in the 1920 Dawson Report and the 1921 Cave Report, but contrary to the impression given by Fox [10], regionalisation was slow to gain influence. However, it was increasingly accepted that a modern hospital system required an infusion of rational principles of planning of the kind becoming prevalent in modern commercial and industrial concerns.

The rapid build-up of commitment to regionalisation coincided with the realisation that the market system had failed. The Medical Officer of Health for the LCC called regionalisation the ‘order of the day’, the ‘New Order’, or the ‘New Deal’ [11]. Lord Dawson observed that the ‘movement of 1920–1 has been reborn and extended under the name regionalisation’ [12]. The idea of regionalisation was also applied to local government reorganisation, which itself was necessary for the purpose of integration within the local government hospital system. The Medical Officer of Health for Glasgow noted that the ‘word regionalism in local government has come to stay’ [13].

It proved much easier to evolve abstract schemes of regionalisation than to apply them to the chaotic voluntary hospital system, which had been resisting calls for integration since before the beginning of the century. Regionalisation was publicly launched by the Sankey Report, produced under the auspices of the British Hospitals Association (BHA) [14]. The BHA established a provisional central council charged with the establishment of regional committees, but in the absence of will or resources, the BHA scheme made virtually no progress. Frustration over this lack of progress contributed to a second and more effective initiative, backed by the resources of Lord Nuffield. The Nuffield Provincial Hospitals Trust, formed in December 1939, quickly evolved plans for dividing the provincial hospital system into 12–15 regions and 65–75 divisions. The first steps towards establishing this organisational framework were made during the early months of the war. It was not possible to make
further immediate progress, but at least this initiative proved that regionalisation was a practical proposition.

State subsidy

Regionalisation possessed the potential to bring about benefits in the medium term, but it made no contribution to the acute financial crisis facing the voluntary hospitals. Within the voluntary hospital world it was increasingly recognised that a substantial subsidy from public funds was becoming an unavoidable prerequisite for survival. The Sankey Report acknowledged that state intervention in welfare was already so widely developed that it was reasonable for it to be extended to the voluntary hospitals. It was suggested that the University Grants Committee model for funding medical schools could be applied to voluntary hospitals as a whole. All that remained to be settled was the size of the subsidy and the method of distribution. This view was accepted by the King’s Fund, and it was widely shared by leaders of the voluntary hospitals [14,15].

Even in a situation of crisis, the retrenchment-minded government of the day refused to pick up the burden of the voluntary hospitals, and their financial problems worsened. The prospect for a major reevaluation of nurses’ salaries, expected as a result of the deliberations of the Athlone Committee, was predicted to be the ‘last straw’ for the voluntary hospitals. In March 1938, the Medical Officer of Health for the LCC wrote to the Minister of Health confidentially, warning that King’s College Hospital faced closure unless it was rescued by the LCC. Four teaching hospitals were listed as candidates for grants-in-aid, and four as requiring urgent support for modernisation [16]. Herbert Eason, the Principal of London University, and former medical superintendent of Guy’s, reported that all 12 undergraduate medical schools in London were facing a serious financial crisis. He proposed an arrangement whereby the LCC would meet the costs of the majority of patients admitted to these hospitals, with the King’s Fund acting as an intermediary for the distribution of these subventions [17]. Sir Harold Wernher, on behalf of the King’s Fund, visited the Minister of Health to report that 36 voluntary hospitals in London, including 5 teaching hospitals, were in ‘low water’ [18].

By the end of 1938 it was evident that the London voluntary hospitals would have difficulty in surviving unless they received much greater subsidy from the public sector. The Times wrote ominously about ‘a position so grave that the possible breakdown of the whole voluntary system looms on the horizon’ [19]. The most obvious source of support was the LCC.

A preliminary discussion between the LCC and the representatives of the voluntary hospitals was held in January 1939, ostensibly to talk in a friendly way about cooperation, but in practice to consider whether it was feasible for the LCC to pay subsidies to the voluntary hospitals. This meeting was important because it demonstrated the seriousness of the problems facing the voluntary hospitals, and it exposed a clash of expectations between the two parties. On behalf of the voluntary hospitals, Sir Harold Wernher frankly admitted that the London hospitals ‘are in a very precarious position and many of those I would like to say are important hospitals’. He warned that massive subsidies would be needed to make the voluntary hospitals into viable concerns. Herbert Morrison (soon to become Home Secretary) indicated that no local authority was allowed to grant subsidies without an appropriate degree of accountability. Echoing a widely held view within the Ministry of Health, Morrison warned that the proposed partnership between the voluntary hospitals and the LCC was likely to have disastrous consequences for the former, since it would cause subscriptions to diminish and precipitate the complete collapse of the voluntary sector [20].

The National Health Service

From the accumulated evidence, the Ministry of Health was convinced that the voluntary hospitals were ‘approaching demise’ [21]. Even before the outbreak of war, officials believed that the future for the hospital service rested between the choices of municipalisation and nationalisation. As the histories tell us, the emergency hospital arrangements during World War II provided a stay of execution for the voluntary system, but the problem of the future became ever more pressing. Respected medical authorities such as Henry Cohen or Sir Farquhar Buzzard urged the merits of proposals for regionalisation, and they extended this idea to involve integration of the municipal and voluntary hospitals, and also to embrace all health services [8, 22]. In his Harveian lecture for 1941, Buzzard pointed out that his scheme for regional health authorities ‘would constitute a National Health Service’. Such a service, he believed, would ‘combat the waste of time and energy and money’ inherent in the existing system [22].

At first, it seemed that the future National Health Service would adopt a form of municipal administration, but the postwar Labour government was persuaded by Bevan to opt for nationalisation and regionalisation of the entire hospital system [23]. This seemed like a radical and audacious plan, and at the time it was controversial, but when seen in context, Bevan’s solution represented the logical application of principles that had been developing for more than a decade.

The National Health Service started its life on 5 July 1948, which was also the designated date or ‘Appointed Day’ for the implementation of the comprehensive programme of reforms in the social services, which effectively established the welfare state in Britain. In the first decade of the NHS, both Labour and Conservative administrations shared in the awesome task of
converting its defective and ramshackle collection of inherited medical services into a modern health service appropriate to the needs and expectations of the second part of the twentieth century. By contrast with the present situation, the two parties were united in their attitude towards the NHS; Iain Macleod, the Conservative Minister of Health, proved to be a shrewd protector of the scheme inherited from Bevan. Bevan’s socialism and One Nation Conservatism pointed to a common solution to the main problems of health care.

In the first decade of the NHS, planners were confronted with problems of an altogether greater order of magnitude than occurred subsequently. They took on the uninviting task of implementing a major transformation in health care without anything like the material and human resources needed for this purpose. The scale of this operation was becoming ever greater owing to scientific advance, the rising capacities of medicine, changing demographic and epidemiological circumstances, and the aspirations of the people, who could no longer be expected to tolerate the indignities associated with charity, the means test or poor relief.

The new health service was an awesome creation; it inherited some 2,800 hospitals with more than 500,000 beds; the whole service employed some 500,000 personnel. The high ambitions of Bevan and the great scale of the operation of the NHS have contributed to the commonly held illusion that the NHS was generously, even wastefully, endowed. However, during the first decade, the current net cost of the NHS averaged about 3.5% of gross domestic product (GDP). This was only marginally more than the cost of the services and personal health expenditure which the NHS supplancted, which I estimate to have amounted to between 3.0 and 3.3% of GDP in the immediate prewar, or the immediate postwar periods. The early NHS was therefore not profligate with resources. The small increment of additional expenditure was clearly insufficient to pay even for the increased costs associated with wider access to services, creating uniform levels of provision, or improving remuneration sufficiently to recruit staff. Considerably greater expenditure would have been justifiable if the new health service had undertaken such huge tasks as modernising its hospitals, building its promised health centres, or expanding services according to the demands of demography or medical advance. The basic fault lay, not in profligacy, but in the lack of political commitment to establishing NHS funding at a level sufficient to meet the requirements of a modern health service. The rigid resource constraints placed on the NHS during its first decade established a precedent, which proved to be a straitjacket out of which the NHS has never effectively broken.

With its restricted budget, the new health service was precluded from advancing on all fronts, but the planners succeeded remarkably well in meeting their main immediate objectives. Consequently, the NHS secured and retained the confidence of the public. From the outset, opinion polls demonstrated a remarkable degree of satisfaction with the NHS; by the tenth anniversary this confidence had spread to the medical profession [24]. The General Medical Services Committee, chaired by Sir Arthur Porritt and established by nine major professional bodies, commissioned a survey which demonstrated 89% satisfaction among the public with the NHS. In the light of its soundings in all parts of the profession, the Porritt Committee discovered that ‘there was no wish to disturb the broad concept of a comprehensive National Health Service’ [25].

The regional hospital system

The regional hospital administration was the most advanced planning feature of the new health service. It was only gradually that the powers of regional hospital boards (RHB) became more clearly defined and sufficiently extended. Regions were especially important in securing much higher levels, as well as greater uniformity, in the provision of consultant and specialist services. The more effective regions, such as the North West Metropolitan or Oxford, assumed many of the functions of a comprehensive regional health authority, taking the lead in innovation, both in administration and in evolving more advanced forms of care. The regions successfully fulfilled the expectations of the 1930s pioneers of regionalisation. The regions levelled up the system to a tolerable degree of uniformity, but their authority was not used to eliminate initiative and independence in the districts.

With remarkable smoothness, speed and efficiency, the RHBs converted the ramshackle and obsolete institutions inherited from their predecessors into a first-class, modern and integrated hospital network. All of this was achieved without the advantage of a major hospital building programme. The hospitals of the NHS were therefore usually grotesque conglomerates of buildings and huts, some dating from the eighteenth century, but great ingenuity was exercised in adapting these antique facilities for housing the most advanced systems of diagnosis and treatment. It was beyond the capacity of the early NHS to build new hospitals, but it was successful in building new casualty and outpatient departments, operating theatres, X-ray departments, pathology laboratories, new boiler houses and heating systems and accommodation for nurses, and it created more acceptable conditions in the wards. The NHS also consolidated and extended the blood transfusion service established during World War II. Between 1948 and 1958 the number of bottles of blood issued more than doubled in England and Wales, and more than trebled in Scotland, representing the contribution of a panel of nearly a million voluntary donors [26].

Improvements in service depended on recruitment
of additional staff and modernisation of training arrangements. Despite fierce competition in the labour market, the NHS was successful in expanding the quantity and quality of its nursing, technical and professional staff. During the first decade, hospital medical staff increased by at least 30% in England, and by about 50% in Scotland. This expansion enabled the NHS to achieve its first and most urgent priority, the provision of a universal consultant service in all specialties [26].

An impression of the scale and character of this achievement was provided in the retrospective account by Sir George Godber, a deputy Chief Medical Officer at the time, and one of the main architects of the new system.

‘General medicine and general surgery were the largest medical specialities in 1948 but increased little after the first two years, while other specialties were established and grew rapidly. Neurosurgery, thoracic surgery, and plastic surgery which had been established in a few centres were quickly provided by the Health Service in every region. Regional radiotherapy services separate from diagnostic radiology were established. The deficiencies in pathology and diagnostic radiology had been exposed by wartime needs and partially remedied, but needed expansion and reequipment. Anaesthesiology developed rapidly into the largest specialty followed by pathology and psychiatry. The increase in consultants was thus not only in numbers, but much more importantly in range of expertise. Geriatrics and child psychiatry developed from almost nothing; urological and cardiological units were established at least in main centres; pathology became subdivided; orthopaedic surgery became predominantly concerned with repair of trauma and defects at birth or of ageing’ [27].

The NHS was thus able to exploit with safety the innovations made possible by the advance of medical science, which greatly contrasted with the situation within the voluntary hospitals as described above by Cohen. The rise in staff numbers and higher professional standards was reflected in proportionate increases in the output of the new health service. For example, between 1949 and 1957 the North West Metropolitan Region recorded a 29% increase both in inpatient discharges and deaths and in new outpatient attendances, a 12% increase in total outpatient attendances, and a 30% reduction in waiting lists. Over the short period 1953 to 1957, the first period for which statistics are available, this region recorded a 41% increase in the work of pathology departments, a 14% increase in diagnostic radiology, a 48% increase in physiotherapy, a 49% increase in radiotherapy, and a 54% increase in occupational therapy [28].

Obstetrics was a major growth area. Childbirth in hospital was no longer regarded as the province of poor women referred to institutional confinement for social as well as medical reasons. By 1958 women in Britain had come to regard hospital as the right environment for ensuring maximum safety in childbirth. Consequently, maternity wards and new maternity hospitals were assuming a high priority in regional development plans. Between 1949 and 1963, there occurred a 20% increase in the number of maternity beds and births per bed increased by 42%. The percentage of confinements in NHS hospitals rose from 45% to 64% in England, from 48% to 73% in Wales, and from 56% to 79% in Scotland [29].

The vast mental health sector represented the most intractable problem facing the early NHS. It would be futile to claim that the mental sector attracted the resources or priority it deserved. Nevertheless, even in this backwater of the new service there were distinct signs of change. There were modest but important shifts in attitudes towards therapy; they marked the beginning of a concerted attempt to arrest the seeming inexorable rise in the population of long-stay patients in mental hospitals, a trend which seemed likely to continue on account of the growth in numbers of psycho-geriatric patients. As a result of advances in chemothera- py, the greater use of outpatient facilities, the availability of short-term treatment for new admissions, and experiments with rehabilitation, the mental hospital population reached its peak in the mid-1950s and by the tenth anniversary of the NHS had entered a distinct decline. This shift enabled regional authorities to abort most of their ambitious schemes for building new mental hospitals and mental handicap institutions. Also, by the tenth anniversary the first efforts were being made to shift psychiatric care into the district general hospitals, by the establishment of outpatient facilities and new acute psychiatric units. Finally, in a few places like Nottingham and Oldham, attempts were being made to develop integrated mental health services involving exploitation of day hospitals and care in the community. The Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (1957) constituted the first major policy document to urge the advantages of community care [26].

Conclusion

Any balanced assessment of the early NHS must be made in context. It is therefore necessary to pay attention to the condition of the health services during the interwar period. This frame of reference is of more than antiquarian value, because the era of the voluntary system contains many of the elements of the market system towards which there is now a reversion. The voluntary hospitals proved unable to meet the demands of medical modernisation. In response to their precarious situation, the leaders of the voluntary hospitals recognised that the future hospital services would depend on public subsidy and differ in their method of management and organisation. Experience had demonstrated that the market system was a failure. There emerged a remarkable degree of agreement that the future hospital service should be based on a comprehensively planned regional basis. This was seen
as the only means to make the most effective use of scarce resources likely to be available for health care.

The pattern of regional hospital administration devised by Bevan represented a faithful attempt at application of this model. Political circumstances and continuing resource starvation precluded fulfilment of regionalisation in its optimum form. Nevertheless, it commanded the confidence of Westminster, Whitehall, the NHS workforce and the public. There was broad agreement that the regional system offered the best prospects for realisation of the ambitious humanitarian objectives of the NHS. This view was shared by expert reviews, including the Report of the Royal Commission on the National Health Service 1979, which constituted the last impartial investigation into the NHS.

This confidence was not misplaced. The remarkable improvements in health care brought about under the planned system were achieved by methods contrary to market principles and which rejected the purchaser/provider split. Even according to narrow criteria of efficiency gains, the achievements of the early NHS were of an altogether higher order than anything claimed for the current wave of experimentation with market systems. The forms of administration and management introduced by Bevan were not an irresponsible and wasteful experiment in socialism, but the logical conclusion of an evolutionary development which had been underway for more than a decade. It is therefore the early NHS, not the chimeras of the marketeers, which represents the realisation of Britain’s native genius in the field of health care.

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