War and European Welfare Exceptionalism

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Social scientists have long vied to explain America's relatively low level of public spending on the welfare state (publicly financed cash and in-kind benefits for citizens) as an aberration from a supposedly high European norm. Many have argued that this is due to uniquely American cultural values, such as individualism or a mistrust of government. Others have pointed to the importance of America's racial divisions, the weakness of organized labor, or the fragmentation of its political institutions (Esping-Andersen 1990; Lipset 1996; Beland and Hacker 2005; Steinmo 2015; Prasad 2019).

But the 19 percent share of U.S. GDP dedicated to public social expenditures in 2019 was similar to that in Australia (17 percent), Canada (18 percent), and New Zealand (19 percent). Rather, it is the extraordinarily high level of social welfare spending in European nations like France (31 percent of GDP), Italy (28 percent), and Germany (26 percent) that stands in need of explanation. Most of the disparity is due to different levels of spending on old age and disability benefits—which are largely the result of the tendency of European states to provide proportionately greater benefits to higher earners (OECD 2019).[1] This has served to crowd out private provision for old age by those who are capable of setting aside funds for retirement.

In this paper, I argue that the European nations' larger welfare states are the product of the transformative effect of the Second World War (as suggested by figure 1),

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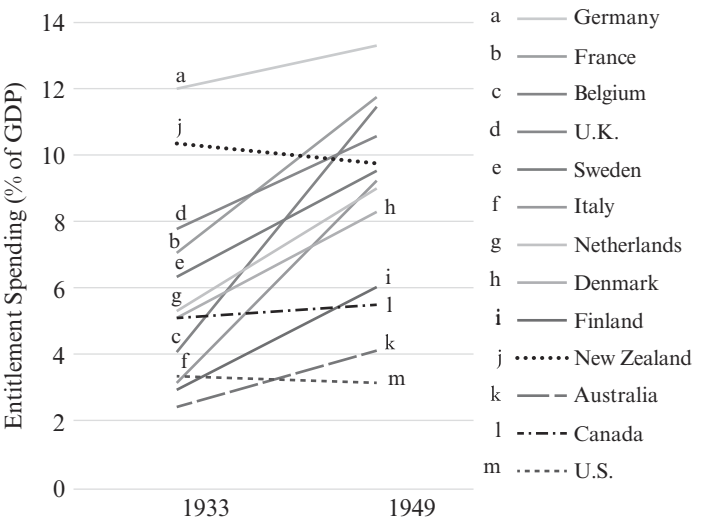
1. Continental European nations provide cash benefits in fairly constant proportion to income, whereas other developed nations provide benefits at lower replacement rates to higher earners.

The Independent Review, v. 28, n. 3, Winter 2023/24, ISSN 1086–1653, Copyright © 2023, pp. 453–477.

Figure 1
Entitlement Spending and Proximity to World War Two



Note: Data for the four non-European countries (New Zealand, Australia, Canada, and the United States) are shown in dashed and dotted lines.

Source: Data from Goodin and Dryzek (1987, 57).

rather than the result of any distinctive internal social, economic, ideological, or political factors. Total war suspended constraints on the expansions of entitlements beyond a needy minority: it hobbled private financing of health insurance and retirement, excused the broad-based tax increases necessary to fill the gap with public funds, and weakened the political capacity of those losing out to resist.[2]

Prior to the Second World War, European democracies tended to prefer incremental targeted expansions of public entitlements as a way to fill basic unmet needs at the least cost and controversy. All nations provided public aid and health care services to those with low incomes, but nowhere were these benefits given to all (Judt 2006, 73). Public spending was not intended to provide a full retirement income for all social classes, but mostly to establish a safety net against poverty in old age. Various proposals were made for the expansion of entitlements to all social classes during the 1920s, but these were consistently rejected in Europe's democracies as elsewhere.

From 1939 to 1945, over 36 million Europeans died from war-related causes; more than half of them noncombatants (Judt 2006, 17). Total war created a multitude of unanticipated and uninsurable risks, which middle-class Europeans could not protect themselves from privately, while decimating existing savings and insurance

2. On how changing circumstances open the door to policy change, see Kingdon (1995). A more moderate version of this dynamic operated in countries at greater distance from the conflict; see Higgs ([1987] 2013).

arrangements. Full mobilization, foreign conquest, comprehensive rationing, and the suspension of democratic checks on governments greatly increased the resources and responsibilities of the state.[3] As a result, there were also many fewer obstacles to the expansion of publicly financed entitlements to wealthier social classes. War had excused enormous hikes in taxes and allowed governments to commandeer civilian resources for public purposes. As peace returned, these resources were diverted to welfare responsibilities that states had assumed during the war—crowding out the reestablishment of private financing arrangements.[4]

Whereas European nations had often previously taxed the rich to aid the poor, the wartime expansion of entitlements up the income scale was accompanied by tax hikes on the working class. The universalization of Europe's entitlement programs was created by the pressures of war, rather than an attempt to prioritize the welfare of the poor—and, indeed, tended to have the opposite effect. This impact has endured: net of taxes, European welfare states today transfer a relatively small share of national income to residents with incomes below the median (Blanchet, Chancel, and Gethin 2021).

Total War Displaces Private Provision in Britain

The pressures of war created a need to restructure Britain's welfare state and eliminated political constraints that would normally have inhibited the universalization of its entitlements.

Prior to the Second World War, Britain's publicly funded entitlements were largely reserved to low-income groups who were not able to provide for themselves privately. Parliament had established means-tested old age pensions in 1908, created subsidized compulsory health and sickness insurance for low-income workers in 1911, and set up a similar arrangement to fund pensions for widows, orphans, and the elderly in 1925. Unemployment benefits were expanded beyond a few cyclical industries following the First World War, but they were subject to a means test (Edgerton 2018).

Health care was generally provided for free to the working class and funded by a patchwork of friendly societies, prepayment schemes, public subsidies, and charitable funds. The compulsory national health insurance system covered physician services for workers with annual incomes of less than £250, while dependents typically received discounted or free care. Municipal hospitals provided free care to the working class, while nonprofit hospitals provided a limited amount of subsidized care for the poor by overcharging the middle class, who increasingly had private insurance (Mowat 1955; Addison 1985, 88–95).

3. This was also true of formally neutral nations such as Sweden, which undertook a major mobilization to maintain their position while being surrounded by belligerents and cut off from normal trading relations.

4. Wartime policymaking considerations led to a great divergence of health care systems (Britain developed its National Health Service; the U.S. exempted employer-sponsored private insurance from taxation).

Hospital spending quadrupled over the 1920s as modern medical capabilities improved, funded mostly through private revenues (Webster 1988; Klein 2001; Roberts 2019, 64).[5] Mutual aid funds grew rapidly, and polls from the 1930s showed little public interest in comprehensive health care reform or the universalization of entitlements (Hayes 2012). Nor did the Great Depression yield substantial policy reforms (Hay and Wincott 2012, 15).

The Labour Party in its 1935 general election manifesto sought less of a policy shift than the coalition government would produce in the Second World War (Addison 1977, 271; Labour Party 1935). A planned economy was established for the war with minimal pushback by private interests or partisan opposition but was in many cases deliberately designed with an eye to reshaping the policy landscape for the postwar period.

The Emergency Powers Act of 1940 authorized the British government to direct any person to perform any service that contributed to the war effort—allowing it to dictate wages, hours, and working conditions (Tombs 2014, 717). Coal, gas, electricity, rail, canals, docks, airlines, and steel industries were all nationalized (Cronin 1991, 155). The Labour Party was given control of the Ministry of Labour and used this power to expand unionization and entrench collective bargaining (Amenta and Skocpol 1988).

The Battle of the Atlantic and the German conquest of Western Europe cut Britain off from many essential supplies. Food was rationed from October 1939, clothes from the spring of 1941, and coal, gas, and electricity from 1942 (Addison 1985, 2–6; 1992, 338–41). British farm incomes tripled over the course of the war, as the government sought to expand domestic production with extensive agricultural subsidies. These were maintained in the postwar period, alongside substantial protectionist restrictions—causing shortages and the rationing of food to last into the 1950s (Klausen 1998, 66–68).

Private insurance had been unable to bear the risks of wartime damage to property. From October 1936, Lloyds of London stopped offering policies to cover them—greatly increasing the role of government as a safety net (Titmuss 1950, 12–22). As the Luftwaffe increasingly bombed civilian areas, 4 million out of Britain's 10 million homes suffered damage, and 250,000 were altogether destroyed (Harris 1992). In anticipation of the Blitz, 1.5 million children and their mothers were evacuated from British cities, and 2 million of those who remained became homeless and needed to be resettled (Titmuss 1950, 251–303).

With so many being displaced across the country, undergoing sudden financial upheaval, or lacking basic personal identification, the complex funding structure of Britain's health care system became unable to cope. In 1941, the government raised

5. Nonprofit hospitals had been prestige institutions, funded initially as charities, but 59 percent of their revenues came from fees by 1938, with revenues from insurance schemes growing rapidly. Municipal hospitals provided free care according to loosely enforced means tests, with only 10 percent of revenues coming from charges and 50 percent from the national government prior to the Second World War.

the eligibility cap for national health insurance coverage of physician services from an annual income of £250 to £420, bringing it well above the national average of £288 (Webster 1988, 47; Thane 1982, 240). Local hospitals saw essential revenue streams choked off and were ill suited to the distribution of wartime needs (Hayes 2012).

From June 1938, the Ministry of Health began organizing the creation of a national hospital service in anticipation of 300,000 air raid casualties and sought to rationalize the allocation of privately and municipally owned hospital beds, equipment, and personnel accordingly (Titmuss 1950, 54–86). At the outbreak of war, 140,000 civilian patients were ejected from hospital beds to make room for the anticipated influx, while outpatient treatment was made free for those injured by the war as well as for servicemen. Nonprofit and municipal hospitals became similarly structured for wartime purposes and increasingly dependent on central government funds (Addison 1985, 97). From 1938 to 1947 nonprofit hospital spending rose from £5 million to £12 million, with no growth in private revenues (Eckstein 1958, 74). Physicians were conscripted into public service, typically with steep pay cuts, and distributed nationwide to serve the new Emergency Medical Service (Titmuss 1950, 137–141; Fox 1986, 95; Fraser 2009, 252). As the Blitz abated, restrictions on civilian admissions to EMS facilities were lifted, and the middle class was increasingly treated in what had been municipal hospitals—effectively ending means tests (Titmuss 1950, 466–501).

The Labour Party identified the war as an opportunity to secure lasting domestic policy gains. As the price of joining the wartime coalition government, it insisted on eliminating household means tests associated with eligibility for unemployment benefits (Bruce 1973, 236).

In 1940, a Labour Party pamphlet commented that "the limit of taxation is what you can get away with—in the atmosphere of war the task is much easier" (Whiting 2001, 61). The top marginal rate of tax on income, which had been 65 percent in 1936, was raised to 97.5 percent in 1941. It would remain at this extraordinary level until 1952 and was not lowered below 83 percent until 1979 (Genovese, Scheve, and Stasavage 2016).

With taxes on the rich at their limit, the need for additional revenues to fund the war justified the unprecedented expansion of taxes to those with more modest means, and income tax rolls were expanded from 4 million in 1938 to 14 million in 1944 (Field, Meacher, and Pond 1974, 17). In October 1940, a purchase tax was established, which rose to 125 percent of the cost of goods in 1948, excluding only essential items like food or fuel, whose sale was rationed (Field, Meacher, and Pond 1974, 94).

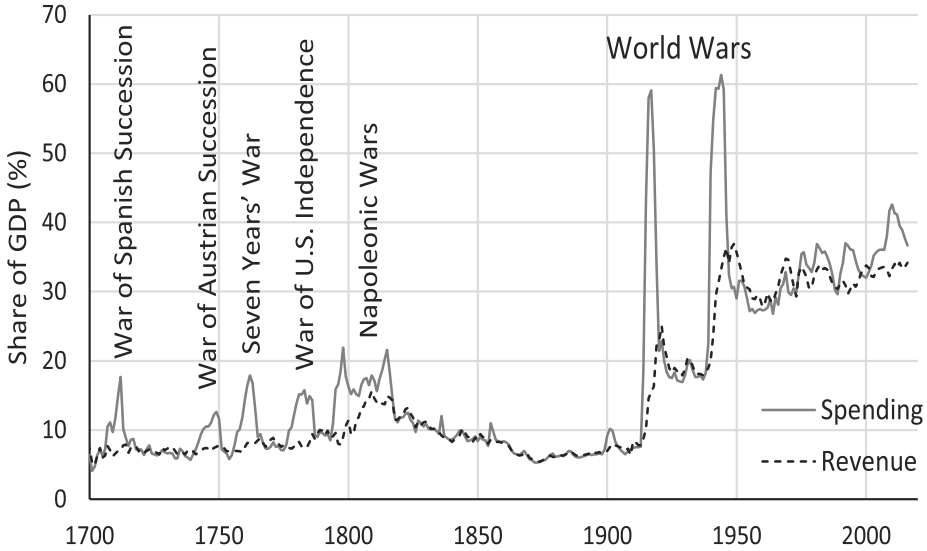
As the economists Alan Peacock and Jack Wiseman observed: "When societies are not being subjected to unusually violent pressures or disturbances, people's ideas about the 'tolerable' burden of government taxation tend to be fairly stable." But "people will accept in a period of crisis, tax levels and methods of raising revenue that in quieter times they would have thought intolerable, and this acceptance remains when the disturbance itself has disappeared" (1969, 26–27).

The level of tax revenue as a share of economic output in Britain has remained remarkably constant over the past three hundred years, with the exception of the largest military conflicts, such as the Napoleonic Wars, First World War, and Second World War, which could not be financed by borrowing alone (figure 2). The 1941 revenue surge wrought a fiscal revolution, permanently loosening the budgetary constraint on public policy, and legitimizing sweeping postwar spending proposals across education, housing, health care, and other social services (Cronin 1991, 136–37).

Building a cross-party coalition to manage the war, Winston Churchill appointed Arthur Greenwood, a Labour member of Parliament, to oversee planning for postwar reconstruction. Greenwood, in turn, commissioned William Beveridge, a liberal academic, to recommend reforms to Britain's various existing schemes of pensions, mutual aid, private insurance, health care finance, and welfare benefits (Addison 1977, 169).

Beveridge's report, published in December 1942, proposed replacing the existing patchwork of arrangements with "a flat rate of benefit, irrespective of earnings, in return for a flat rate of contribution from all" (17). This would eliminate means tests from state pensions for the elderly, widows, and orphans, along with those for unemployment, maternity, disability, and funeral benefits (Fraser 2009, 254). It would also establish cash payments for each child and "a comprehensive national health service" to provide for every citizen "whatever medical treatment he requires,

Figure 2
Tax and Spending Shares of GDP in the U.K.



Source: Bank of England, n.d.

in whatever form he requires it"—rationalizing the delivery of medical care through full state funding, while extending free care from low-income workers to all citizens (Beveridge 1942, 158).

Beveridge's promises benefited from a huge publicity campaign, intended to boost war morale, which blended with wartime propaganda in an era of tight censorship (Macnicol 1998, 387). From dawn on the day of the report's launch, the BBC (the state radio monopoly) broadcast its details across the British Empire in twenty-two languages (Addison 1977, 217). As Royal Air Force planes returned from bombarding the Nazi war machine, they dropped millions of leaflets over continental Europe extolling the principles of the Beveridge Report (Morgan 1992, 37).

The report initially met with guarded approval from Parliament, which was concerned that universal benefits would either be so low they would fail to secure a basic subsistence, or so high that they would deter employment and thus place a great burden on the economy (*New York Times* 1942). Churchill spoke for many concerned about the cost when he initially suggested that he did "not wish to deceive the people by false hopes and airy visions of Utopia and Eldorado" (Harris 1981; Fraser 2009, 260). Yet, backbench Labour MPs wholeheartedly embraced the proposal, seeing it as an endorsement of the socialist principles they had long advocated, and pressed their leaders for its rapid implementation (*New York Times* 1943b; Jefferys 1987, 129–31). The Ministry of Information reported that industrial workers believed that the war proved the government had money to spend, and that "cynics who said 'This is just propaganda to keep us at it till the war is over' were looked upon as disturbers of the peace" (Beveridge 1954, 123–24).

The leader of a committee appointed by the Conservative Party to assess the merits of the Beveridge Report acknowledged the need to expand and rationalize existing benefits but objected that "whereas his diagnosis relates to Want, his proposals are very largely devoted to giving money to people who are not in Want" (Jones 1992, 73–74). Chancellor Kingsley Wood argued that paying benefits to the affluent would be farcical, but the cabinet determined that identifying genuine need and dependence in a time of war would be administratively problematic (Baldwin 1990, 129). Though Churchill was resistant to the cost implications of establishing large middle-class entitlements, he had little appetite to dispute popular domestic policy proposals while there was a war to fight (Jones 1992, 64–90).

The Labour Party won its first outright parliamentary majority in the June 1945 general election, defeating a Conservative Party that it portrayed as responsible for the 1930s failures of appeasement and high unemployment (Zweiniger-Barglelowska 1994). Labour benefited from an unprecedented surge in middle-class areas, but popular support for policy reform was vague and shallow (Gladstone 1999, 40; Kynaston 2008, 45). It pledged sweeping reforms to industry, housing, health care, and social security (Labour Party 1945). But the greatest part of its radicalism was in retaining the central government controls that wartime had generated.

The National Health Service Act of 1946 made available free medical treatment to all British residents. It completed the nationalization of nonprofit and municipal hospitals. This left many specialist physicians with little ability to operate independently of the state. To bring in holdouts from private clinics, Minister of Health Nye Bevan boasted that he "stuffed their mouths with gold" (Klausen 1998, 38–39). The wartime expansion of national insurance combined with the retention of wage controls to leave general practitioners little capacity to resist (Fraser 2009, 280). The political hard work required to socialize health care—restricting patient access to care, redistributing funds between hospitals, shrinking the private insurance industry, cutting payments to physicians, and raising taxes to fund expansions of benefits—was all done by the war.

The National Insurance Act of 1946 sought to consolidate existing cash benefit programs along the lines proposed by Beveridge. The income-based cap on eligibility was eliminated, so that every resident of working age with an annual income over £104 was required to pay a uniform tax in return for uniform cash benefits in case of sickness, industrial accidents, unemployment, and pensions in old age (Marwick 1968, 345–47; Cronin 1991, 153).

Though Beveridge had sought universal benefits at a subsistence level, the Treasury favored universalization for the opposite reasons. It viewed the universal entitlement as a way to repackage pensions as an "insurance" program, tied to contributions rather than needs, which could therefore be cut *below* a subsistence level—with benefit levels being eroded further by inflation over time (Macnicol 1998, 374–93). Married women would no longer receive benefits independently of their husbands' contributions (Deacon 1995, 79; Macnicol 1998, 354). Unemployment, sickness, and disability benefit levels had already been reduced *below* their prewar level, as a result of wartime inflation (Myles 1984, 41). When national insurance was universalized, benefits were worth only 19 percent of average wages—inducing people to delay retirement, which also saved money (Pollard 1983, 266).

Prior to the war, those paying substantial income taxes or receiving unemployment, disability, and orphans' pensions each benefited from child allowances. The war extended allowances to evacuees and the children of servicemen, leaving low-paid civilian workers as an anomalous exception. John Maynard Keynes proposed the universalization of child allowances in his 1940 book *How to Pay for the War* as a way to offset the impact of wartime regressive taxation, rapid inflation, and falling real take-home pay for working families with the most children to look after (Keynes 1940). Beveridge endorsed this approach, and the interim Conservative government established uniform five-shilling weekly allowances for all but first-born children prior to the 1945 election (Thane 1982, 230–43).

When victory was secured in 1945, Britain found itself needing to pay foreign creditors for a record national debt that had reached 220 percent of GDP (Cronin 1991, 162; Kynaston 2008, 20). Additional loans were depleted within two years, and the British pound was devalued in 1949 from $4.03 to $2.80 (Klausen 1998, 65).

The government retained rationing to prevent the import of consumption goods putting further downward pressure on the currency (Addison 1985, 29–53; Klausen 1998, 78–79).

The expansion in eligibility for entitlements was therefore not matched by an expansion in resources dedicated to them. From 1938 to 1951, public spending on social security *fell* from 5.4 percent to 4.8 percent of national income. Public spending on education ticked up from 2.0 percent to 2.2 percent, as did that on housing, from 0.4 percent to 0.5 percent (Tomlinson 1998). But while Britain needed to replace its housing stock, which had been devastated by war, the continued rationing of building materials meant that public housing accounted for 82 percent of new construction, and fewer houses were built in 1950 than the late 1930s (Addison 1985, 56–60).

Public spending on health care was increased more substantially, from 1.3 percent to 3.3 percent of GDP—but this served mostly to crowd out private spending by picking up hospital charges, physician fees, and insurance premiums that had previously been incurred privately by the middle class (Tomlinson 1998). Whereas the public and private sectors had together spent 4.2 percent of GDP on health care in the mid-1930s, by the 1950s private health spending had largely been eliminated and the National Health Service spent only 3.0 percent (Appleby 2018; Edgerton 2018, 221).

Although medical technology had greatly progressed, and facilities needed to be built to house it, real hospital capital expenditures in 1952 were only a third of those in 1938—half the replacement level needed just to make up for depreciation (Eckstein 1958, 258; Tomlinson 1997, 248). Rather than eliminating the inefficiencies of the distribution of old Victorian-built hospitals, Britain's NHS ossified them and would build no new hospitals until the 1960s (Webster 1990, 151; Tomlinson 1998). Monopsony constraints on physician compensation also came at a cost: a third of newly trained British doctors emigrated in the years following the creation of the NHS, five times the rate prewar (Seale 1962; Carroll 1966).

The NHS was established at the same time as the antibiotic revolution, and while the mortality rate among white-collar professionals was reduced from the 1930s to 1960s, the death rate among unskilled workers rose (Black et al. 1982, 65–74; Le Grand 1982). The NHS greatly expanded health care entitlements up the income spectrum, but the total number of doctors and hospitals had not increased, leading the economist Gordon Tullock to conclude, "There was a shift of medical resources from the poor to the middle class, and the poor suffered from it" (2005, 159–68). A report commissioned in 1976 by Britain's Labour government contrasted this with the *reduction* in medical inequality in the United States, which it attributed to the increase of targeted means-tested medical care through Medicaid (Black et al. 1982, 90–111).

The egalitarian midcentury distribution of income necessitated a broad distribution of taxation. In 1948, all income taxes accounted for only 38 percent of

government revenues (Tomlinson 1997, 272). Taxes of up to 97.5 percent on the rich did not even cover defense expenditures, and so the expansion of entitlements to the middle class required heavy taxes on lower-income households (Briggs 1952, 373).

Keynes supported the "fiction" of insurance contribution as a useful excuse to raise revenue, but deemed Beveridge's proposed flat payroll tax a "poll tax on the employed and an employment tax on the employer—both very bad kinds of taxes" (Fraser 2009, 256). The historian A. J. P. Taylor scorned it as a "retrograde principle . . . against which Englishmen had revolted as long ago as 1381" (1990, 688). Payroll taxes initially accounted for two-thirds of the cost of national insurance, and contributions from progressive general revenue sources subsequently declined steadily over time (Field, Meacher, and Pond 1974, 77). To fund the NHS, in 1947, taxes on beer were increased, while the tobacco duty was doubled—falling heaviest on the working classes, and together accounting for 28 percent of government revenue (Tomlinson 1997, 272; Whiting 2001, 93).

Overall, from 1938 to 1949, the increase in taxes paid by households with incomes of less than £500 per year (from £499 million to £1,791 million) exceeded the increase in government spending on benefits they received (from £417 million to £1,652 million) (Weaver 1950; Peacock 1954, 157).

Rising taxes on working-class voters and dissatisfaction with continued rationing were widely viewed as the cause of Labour's election losses in 1950 (Whiting 2001, 103). After losing power the following year it would take the party a further thirteen years to regain it. Yet, as Peacock and Wiseman noted, while the 1950 budget "involved a tax burden that would have been unthinkable to a prewar government or electorate . . . there was no serious argument for a return to the prewar situation" (1969, 27). Once the middle class had become accustomed to receiving costly entitlements, they could not easily be weaned off them.

Spreading Bismarckian Entitlements by Blood and Iron

The Bismarckian welfare state was not initially popular in Germany because it imposed broad-based taxes in return for the promise of benefits far in the future (Rodgers 1998, 224). Yet, Germany's Second Reich did not make it easy for interests to mobilize against its enactment, and the Third Reich would be even less bound by democratic constraints in exporting similar arrangements across Europe.

Germany's welfare state had been established by Otto von Bismarck as a state-directed system of compulsory "social insurance" benefits, funded by payroll taxes, administered by private entities, and limited by income eligibility caps to the working class. Established to support an authoritarian regime, it survived the First World War, the collapse of the German Empire, and the fall of the Weimar Republic (Manow 2020, 39). By 1933, Germany's system of entitlements was still much larger than those in any other European nation (figure 1).

The Nazis gradually expanded eligibility and state control over the Bismarckian schemes, and sought to replace them with a system of universal benefits funded by general revenues. Although these promises were never implemented in full, they often plundered social insurance funds for military purposes and were eager to impose similar arrangements on nations they conquered.

In 1883, Bismarckian Germany made participation in health insurance funds mandatory for workers with annual incomes of less than 2,000 marks. Six years later, it would do the same for old age pensions (Rosanvallon 1981, 149). These schemes guaranteed a subsistence income to industrial workers who became ill or old and gave support to family members when workers died (Myles 1984, 33). Like other European welfare states prior to World War Two, this arrangement was limited to the working class and left those higher up the income scale the responsibility to provide for and insure themselves through private markets.

Hyperinflation following the First World War depleted the system's accumulated reserves by 90 percent, which destroyed the actuarial basis of old age, invalidity, widows, and orphans' pensions, and forced a shift to pay-as-you-go financing (Teppe 1977). Unemployment benefits were introduced for low-income workers entitled to social insurance in 1927 as the economy boomed, but the Great Depression caused their costs to soar, and the dispute over financing them triggered the collapse of the ruling coalition in 1930—opening the door for the Nazi Party to make major parliamentary gains for the first time (Pollock 1930; Guillebaud 1941; Rimlinger 1971, 132).

The original 1920 Nazi Party platform demanded "an expansion on a large scale of old age welfare" (NSDAP 1946). Nazi theorist Alfred Rosenberg saw union-controlled social insurance funds as a coffer for left-wing parties and a "source of power of the most dangerous kind" and argued that it was "primarily due to social insurance that the German worker did not lose faith in Marxism" in the postwar period (NSDAP 1931). The new regime abolished participation by employers and workers in the management of funds, centralizing control in the state through the German Labor Front (DAF), led by Robert Ley (Stolleis 2014). A senior official asserted that "the insurance ideal in social insurance must be replaced by the idea of maintenance, that is, everyone who has done his duty toward the people's community will be provided for" (Rimlinger 1971, 133–34). The Nazis hoped that this would make entitlements a bond of racial solidarity—"the organized expression of the comradeship that grew out of the national community" (Schmidt 2005).

To win power, the Nazis attacked late-Weimar cuts in pension benefits and increases in unemployment insurance payroll taxes, but then retained them as unemployment subsided—generating a huge surplus (De Witt 1978; Eghigian 2000, 272–77). As the economy boomed in the 1930s, the regime lengthened sick pay and expanded health insurance to cover maternity and dental benefits, while reducing the payroll tax (Companje and Hendriks 2009). Yet, from 1938, social insurance assets were transferred to the Reich, which used them for road construction and

rearmament—and most of what was left was lost as the Germans were defeated in 1945 (Tennstedt 1988).

The Nazis nonetheless sought to capitalize on the reputation of Bismarckian Germany as social policy pioneers (Patel and Reichardt 2016). In a November 1939 speech at the Munich beer hall, Adolf Hitler jeered that Britain's animosity to his regime came from resentment of "the Germany which sets a dangerous example to them . . . the Germany of social welfare, of social equality, of the elimination of class differences—this is what they hate!" (Patel 2015).

With an eye to the battle for international public opinion, Hitler commissioned Ley, whom he deemed his "greatest idealist," to work out a comprehensive pension scheme. Ley proposed replacing social insurance with universal benefits under direct state control—assuring housing, medical care, consumer goods, old age pensions, and life insurance benefits to all citizens, regardless of income (Smelser 1988, 4). He promised uniform pensions for the disabled and those reaching age sixty-five, eliminating means tests and links to contributions, with benefits at a level "natural for a German"—excluding those deemed "public enemies" or "foreign races," such as Jews (Rimlinger 1971, 134; Sachsse and Tennstedt 1992). Ley pointed out that direct state control of pensions was more in line with Bismarck's original objective of using entitlements to bolster an authoritarian regime by enriching the state and strengthening political discipline (Teppe 1977).

The historian Kiran Klaus Patel notes that "the British Beveridge report was also deeply informed by simultaneous debates in Robert Ley's DAF and the Reich Labour Ministry, and vice versa" (2015, 30). When the Nazis responded to the Beveridge Report by boasting that their nation had long had a similar arrangement, Beveridge sought to deny that he drew any inspiration from Germany (*New York Times* 1943a). As a substantive matter, their proposals were very similar, with the main difference being that Ley sought to employ income taxes to raise funds, while Beveridge sought to rely on uniform premiums (Schmidt 2005).

Though both countries were eager to boost wartime morale by promising a future that gave all things to all men, their militaries similarly had first claim over resources. Hitler, like Churchill, adopted a "wait and see" attitude to reform (Teppe 1977). Ley argued that "power is money" and promised that victory in war would provide the funds to make it possible (Geyer 1988).

Nonetheless, plunder from conquered lands did allow steps in that direction to be taken. The historian Götz Aly has noted that "the basis for domestic stability in Hitler's Volkstaat was its continual bribery of the populace via the social welfare system." Child benefits and household subsidies were increased by 39 percent in 1939, 28 percent in 1940, 56 percent in 1941, and 96 percent in 1942 (Aly 2007, 72). Social insurance funds were expanded to self-employed craftsmen in 1938 as well as to farmers and their wives in 1939 and viewed as moving the nation toward the comprehensive "benefits scheme for the German people" intended by Ley (Sachsse and Tennstedt 1992; Schmidt 2005).

As the Germans were defeated, costly promises for sweeping reform were not carried through to the extent they were in Britain. The political scientist Daniel Béland notes, "The Nazi Ley Plan fell into oblivion, whereas the Beveridge Report became a focal point for social policy debates in the years to follow" (Béland et al. 2022).

Nonetheless, the Nazi regime succeeded in revolutionizing entitlement policy in the lands they took over. The Anschluss led to the imposition of various policies that Austria had repeatedly rejected during the 1920s: old age pensions for blue-collar and agricultural workers, unemployment benefits, and broad child allowances. These were funded in part by the expropriation of Jewish property and, later, the plunder of neighboring lands. The structure of benefits established by the Nazis in Austria remained postwar, stripped of their racist elements. This left the nation with a relatively large welfare state, where it had previously had a small one (Obinger 2018).

The Nazi takeover similarly transformed the Dutch welfare state. Whereas the Netherlands (which had been neutral during the First World War) increased its top marginal income tax rate only from 3.2 percent to 4.8 percent from 1914 to 1918, a German decree on August 28, 1941, would hike it from 4.8 percent to 65.0 percent—a level below which it would not be reduced until 1990 (Genovese, Scheve, and Stasavage 2016).

Although the Netherlands in the years following the First World War had established pensions for low-income workers in case of old age or disability, repeated attempts to make health insurance compulsory failed (Luyten 2018, 337). Struggles between physician associations, health insurers, and trade unions made it difficult to reach agreement on reforms—and each resisted proposals to increase state control (Luyten 2015; Willemsen 2020). The share of the Dutch population covered nonetheless increased rapidly in the interwar period, as commercial insurance, mutual benefit societies, and labor plans proliferated (Companje and Hendriks 2009, 162).

With the continent subject to a British naval blockade, the Nazis sought to establish a currency and customs union with the Dutch to create a unified economic bloc. Yet, as German labor costs were 25 percent to 30 percent higher, it was seen as necessary to increase wages and taxes in the Netherlands across the board to avoid putting German industry at a major competitive disadvantage (Asselberghs 1982). Nazis viewed the export of German social insurance arrangements as justifying the establishment of payroll taxes, which would reduce the labor cost disparity and expand the market for German insurers to participate in (Companje and Hendriks 2009, 178; Bertens 2021, 99).

The Nazis also saw comprehensive social benefits and principles of national solidarity as distinguishing National Socialism from the practice of liberal capitalist nations of targeting assistance at the poor. In June, Arthur Seyss-Inquart and Herman Göring established a policy of equal rights for Dutch and German citizens, seeking to win popular support for the occupying regime as a unified Germanic

community. For old age pensions, disability benefits, and accident insurance this merely meant expanding benefits; but it required an overhaul of Dutch health policy arrangements (Vonk 2012).

An August 1941 health insurance decree by the occupying regime made health insurance coverage mandatory for low- to middle-income workers enrolled in sickness funds. This displaced market-based health insurance, funded by premiums, for state-determined benefit packages organized through sickness funds, paid for by an additional 4 percent payroll tax (Vonk 2012; Bertens and Vonk 2020). Mandatory participation was extended to domestic servants in 1942 and the unemployed (with a state subsidy) from 1944. As working-age individuals were transferred to compulsory plans, the elderly remained in private insurance, causing the average medical costs of their enrollees to spiral upward and their enrollment to shrink (Companje and Hendriks 2009, 178).

Trade union unemployment insurance funds were merged and taken over by a state-controlled union, while pensions for old age, disability, widows, and orphans were increased—with the intent to demonstrate that National Socialism could bring a better deal than private management. Child allowances were introduced in 1941, and the self-employed brought into social insurance coverage from 1943. Even after the new entitlements were established, payroll taxes remained substantially lower than in Germany, and so an additional 4.5 percent "equalization levy" was imposed with the promise that the large surpluses it generated would be used to expand retirement and health care benefits postwar (Asselberghs 1982; Kappelhof 2004).

Those promises would not be fulfilled by the Nazis, but the 1941 health insurance decree remained in force until 2006, and it still forms the foundation of the Dutch health care system (Willemsen 2020).

Revolutions by Decree in Belgium and France

Belgium and France had both established limited entitlements prior to the Second World War, but attempts to turn these into comprehensive benefits for all social classes had been fiercely, and successfully, resisted. In both nations, such sweeping reforms were eventually imposed by decree during a period of extraordinary politics at the end of the war. These structures were already entrenched when normal democratic elections and legislative politics resumed, and they continue to set the confines of entitlement policy in both nations to this day.

Belgium suffered more than most nations from the first world war, as it was a battleground throughout the conflict. The economy collapsed, the government fled to France, and the nation would have starved without emergency food aid from the United States. To provide emergency relief, Belgium established a general old age pension in 1920, which was turned into a permanent contributory scheme in 1924

(Luyten 2018, 328–31). But Belgium's welfare state was otherwise limited, with voluntary health and sickness insurance by mutual aid societies supported through tax exemptions and state subsidies from 1894 (Companje and Hendriks 2009, 88).

Prior to the Second World War, Belgium had a patchwork of private insurance, employer-sponsored benefits, and public assistance (Vanthemsche 2017). Trade unions had dominated the provision of unemployment insurance, but when the government in 1938 proposed making the unemployment insurance compulsory for blue-collar workers, employers opposed the reform as relatively low labor costs had been key to the nation's economic competitiveness (Luyten 2015). Mutual aid funds, often organized on confessional lines, similarly opposed proposals to consolidate them into a single mandatory entity (D'Haese 2009).

In 1941, as it had in the Netherlands, the occupying Nazi regime sought to impose a comprehensive social insurance system on Belgium. But this ran into opposition from confessional, insurance, and medical interests, and fell down the occupiers' list of priorities as the war went on, before being abandoned (Companje and Hendriks 2009, 155; Luyten 2015, 254).

Nonetheless, a group of socialists, trade union leaders, and civil servants began meeting in secret to plan for the postwar world. Inspired by the Beveridge plan, they sought to exploit the wartime absence of political constraints to establish comprehensive reforms as soon as they returned to power (Van Leberge 2021). They proposed a system—known as the Social Pact—of universal health care benefits and cash payments (for the disabled, unemployed, elderly, and parents of children) tied to contributions financed by a payroll tax (Vleminckx 2009).

A national unity government was established by the former prime minister returning from exile in September 1944, and on December 28 (while the Battle of the Bulge was still raging over Belgian territory) the Socialist Minister of Employment and Social Welfare Achille Van Acker imposed the sweeping expansion of the nation's entitlement programs by decree law. There was no advance public discussion, opportunity for all stakeholders to offer feedback, or parliamentary debate, and the Conservative and Communist Parties were deliberately kept in the dark. No free and competitive elections would be held until 1946, after the new system had already been implemented (Pasture 1993; Vanthemsche 2017).

Mutual insurers opposed the strict regulation of premiums and benefits they could offer, while doctors feared restrictions on the sale of their services—but neither had a chance to make a case to the public against the reforms (Companje and Hendriks 2009, 220). Although some businesses had been consulted, the nation's major mining, steel, and financial industries were opposed. Walloon socialist unions had given their assent, but socialist unions in Flanders and Brussels were against it (Strikwerda 1998). This was also the case with rail unions, who believed their members were already well protected against these social risks and argued that the government was "betraying the interests of the working class" by making them pay for the expansion of benefits (Vleminckx 2009).

It is hard to imagine that any democratic government under normal political circumstances would have been able to suddenly impose the huge 23.5 percent payroll tax (7 percent to fund pensions, plus 6 percent for health and sickness, 2 percent for unemployment, 6 percent for child benefits, and 2.5 percent for paid annual leave) needed to fund the new system (D'Haese 2009). Yet, rapid inflation had caused real wages in Belgium to plummet by 85 percent from 1938 to 1944, and so the leap in taxes was more than offset by the return of wages to peacetime levels (Cassiers and Scholliers 1995).

The general structure of the 1944 reforms, which were established as a "provisional" agreement, survives to this day (Vanthemsche 2017). Yet they did little to redistribute funds to those unable to provide for themselves, due to its capped payroll taxes, which took a larger share of smaller incomes, as well as the greater longevity and disproportionate consumption of health care services by wealthier social classes. A 1966 report considering whether the system benefited the poor warned that "if redistribution is not pursued systematically, the opposite outcome cannot be excluded" (Deleeck 1967).

As elsewhere in Europe, the chaos of the First World War first provided the impetus for France to expand its social safety net. Over 7 percent of the French population was killed in the conflict, and millions more were injured (Domin 2019). This bankrupted many hospitals, and public spending was rapidly expanded to make up for the shortfalls (Smith 1998; 2003). After Alsace-Lorraine was reconquered from Germany, France inherited the Bismarckian system of entitlements for the working class there, and a bill was introduced in 1920 to extend it nationwide to assure revenues for hospitals (Godt 1989, 191).

Following years of struggle over payment arrangements, this measure was eventually enacted in 1928, extending mutual insurance coverage from 21 percent to 45 percent of the population. Low-income industrial workers received health care, sickness, retirement, and disability benefits, in return for a 10 percent payroll tax. This proved to be a windfall for insurers and was also popular with physicians, who received a guaranteed reimbursement floor without losing the right to contract freely and determine fees. In practice, it covered only a third of the cost of care. Strikes broke out in textile and iron industries when funds were first withheld from paychecks. The self-employed, such as farmers, managed to secure exemptions, as they had from a similar earlier pension system (Douglas 1932; Galant 1955, 15–17; Ambler 1991, 7; Feller 2005; Domin 2019).

Following the Nazi conquest of France, the collaborationist Vichy regime saw the preceding pluralist era of social reform, which had provided a safety net limited to the working class, as excessively liberal. Its leader, Philippe Pétain, denounced the "weakness of the state and the inadequacy of the governmental apparatus" and promised to "put an end to the reign of economics and its immoral autonomy" (1940). Pétain prohibited independent interest groups, allowing only state-sponsored organizations to speak for business and labor (Dutton 2002).

The French economy was greatly squeezed by the war and occupation. Seizures and reparations extracted by the Germans rose to 56 percent of French GDP in 1943 (Occhino, Oosterlinck, and White 2007). Whereas the residents' average daily calorie intake by 1941 had fallen from 3,000 to 2,800 in Britain, and 2,570 in Germany, in France it plummeted to 1,300 (Tombs 2014, 720).

As inflation soared, benefits under the contribution-linked pension system, which was far from maturity, proved inadequate (Le Crom and Hesse 2000; Valat 2020). In response, the Vichy regime seized the accumulated reserves to establish a uniform pay-as-you-go benefit (Feller 2005; Valat 2006; Mattara 2017). As inflation also pushed up tax revenues, pension spending increased threefold in real terms from 1940 to 1944 (Valat 2020). To establish an income floor for families, the government universalized the system of child allowances, which had previously gone only to salaried workers, into a benefit that also went to the unemployed, sick, and pregnant (Le Crom and Hesse 2000). Meanwhile, eligibility for health care benefits was greatly expanded, and from 1939 to 1944, public spending grew from 46 percent to 71 percent of hospital revenues (Smith 2018, 141).

Many leading French technocrats had been exiled to London, and from 1943 Pierre Laroque began crafting a reform with many of the same objectives as the Beveridge plan's (Baldwin 1990, 163–64; Kerschen 1995). Laroque (1948) sought the "integration of all rules and all benefits within a single framework," by restructuring the mandatory benefit funds established for low-income workers in 1928, and expanding them to the whole population, regardless of income or occupation.

The liberation swung French politics far to the left (Galant 1955, 24–49). After the breakdown of the Molotov-Ribbentrop Pact, Communists had gained much influence over the armed Resistance movement, and the provisional government of twenty-two established by the Allies included only a single conservative (Dutton 2002, 209–12; Luyten 2015).

On October 4, 1945, before the first postwar elections, the provisional government decreed "ordonnances," establishing a sweeping system of health care, retirement, parental, and disability benefits known as "sécurité sociale." It eliminated the caps on eligibility that had limited prewar entitlements to low-income workers and declared the intention to expand the system to all French citizens (Peterson 1960, 19–39). The reform reestablished the promise of larger benefits to those with higher prior earnings but retained pay-as-you-go financing (Valat 2020).

There was widespread opposition and refusal to register or pay when the sécurité sociale system went into force (Mattera 2017). But, as wages by 1947 had fallen to 60 percent of their 1938 levels, the subsequent rebound in the economy meant that the hike in payroll taxes was little noticed by workers, as more than three-quarters of it was paid pre-wage by employers (Laroque 1948).

Business was generally opposed to the overhaul, which imposed substantial payroll tax hikes, but found itself deprived of organized representation after the fall of the Vichy regime (Valat 2006). Independent workers were generally opposed, as were

medical societies and Catholic workers' groups, while socialists were half-hearted in support of universalizing benefits and more focused on nationalizing industry (Galant 1955, 58; Mattera 2017). Mutual insurers mobilized belatedly and, along with medical societies and opposition politicians, protested that the provisional government should have waited until the proposal could be debated by a freely elected parliament (Galant 1955).

Following elections in 1946, which made the Christian Democratic MRP (Popular Republican Movement) the largest party, normal politics began to resume. This allowed miners, civil servants, and railway workers to retain occupation-specific funds, while small businesses and the self-employed secured exemptions from the scheme (Naylor 2015). As the reform shifted control of funds from employers to unions, it did much to make organized labor into ardent defenders of the new arrangement (Nord 2012, 79; Luyten 2015).

The design and segmentation of occupational schemes meant that France's new system achieved very little redistribution from rich to poor (Rotier and Albert 1954). Indeed, as middle-class interests flexed their political muscles to veto provisions that would have left them worse off, poorer workers found themselves disadvantaged by the overhaul (Baldwin 1990, 158–207). From 1938 to 1952, the share of government expenditures dedicated to sécurité sociale benefits rose from 16 percent to 27 percent as benefits were expanded to the middle class, an increase that was mostly offset by a major reduction in the share of expenditures devoted to public assistance for the poor, from 14 percent to 7 percent. Over the same time period, the share of government revenue received from individual income taxes fell from 20 percent to 6 percent, while that from payroll taxes soared from 15 percent to 28 percent (Peterson 1960, 49–50).

As overall tax revenues had not increased, the shift from income to payroll taxes meant a highly regressive change in the distribution of taxes (Laroque 1948). By 1952, the share of national income taken in personal income taxes was lower in France (5 percent) than in the United States (13 percent), while that drawn from consumption and payroll taxes was much higher: 31 percent in France versus 11 percent in the U.S. (Peterson 1960, 61).

Over subsequent decades, the cost of financing expansive health and retirement benefits for the middle class would grow steadily due to growing medical capabilities and rising life expectancy—further inflating the burden of payroll taxes on low-income workers and those who sought to employ them. Today, the best predictor of how much assistance European nations provide to their working-age poor, net of taxes, is how little they spend on public pensions for affluent retirees (Hammer, Christl, and De Poli 2021).

Conclusion

Europe's costly welfare states are distinguished from those elsewhere in the Western democratic world by the relatively generous benefits they provide to their elderly, disabled, and unemployed citizens from higher-income groups. Europe's entitlement

state has not always diverged in this manner. Rather, as I have shown, its current size and shape are the product of the pressures of the Second World War, which increased demand for bigger government by decimating private insurance and savings schemes, greatly increased the supply of tax revenues to central governments, and suspended the democratic capacity of those losing out from the expansion of public programs to resist.

In Britain, the universalization of entitlements was enacted by an all-party coalition government; in the Netherlands and Austria by the occupying German regime; and in France and Belgium by unelected provisional governments. In each of these cases, the suspension of democratic politics (with all its contestation and controversy) permitted the revolutionization of the welfare state, with lasting effect.

Social scientists often point to ideas, interests, and institutions to explain differences in public policies, but the greatest changes in such factors are themselves driven by extraordinary exogenous shocks to circumstances. In *Crisis and Leviathan*, Robert Higgs ([1987] 2013) documented the responsibility of major crises and emergencies for ratcheting up the size of government in the United States over the course of the twentieth century—the foremost of which were the two world wars. The Second World War imposed an even more dramatic upheaval on Western Europe, and the continent's supersize welfare states remain as a legacy of the even greater disruption that they suffered.

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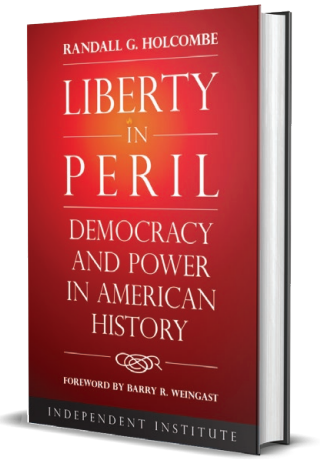

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