

The end of freedom from fear?

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Thank you for inviting me to speak to you today. It is a considerable honour. It would also have given my father a degree of wry satisfaction. He was a consultant paediatrician and an enthusiastic supporter of the NHS. He would have been enraged by what is happening to it now.

I don't need to spend any time describing to you, of all people, what is happening now – the drive to restore something rather close to the market-based system that existed in Britain before 1948. But people outside the NHS, and many of those working in it, have a very imperfect understanding of what is happening, because the government has been extremely careful to conceal its true aims. Every step along the path leading from an integrated public health service back towards something like the 1930s has been represented as a 'reform' in the interests of efficiency, and, now, of giving people greater 'choice'.

It is really only since Patricia Hewitt announced the handing over of NHS treatment centres to private companies last month that the real nature of the government's intention to privatise clinical care has begun to be generally recognized. It was all clearly spelled out very clearly in *The NHS Improvement Plan* in June last year.¹

Professor Chris Ham, who as Director of Strategy in the DH was instrumental in drafting the plan, described it very accurately in an interview with the Financial Times in April this year, after he had left the Department: 'The foundations have been laid', he said,

for the complete transformation of health care delivery. We are shifting away from an integrated system, in which the NHS, the National Health Service, provided virtually all care, to a much more mixed one, in which the private sector will play an increasingly major part. The government has started down a road which will see the NHS increasingly become a health insurer.²

But when John Reid presented the *Improvement Plan* to parliament he made no mention of any of this. What he said was that

... our national health service will not only retain its basic fairness and equity, but be able to meet the expectations of all our people in this new century irrespective of their wealth, race, geographical dispersion or social standing and background.

That is now the national health service started and that is how we will continue in this century.³

And in *The NHS Improvement Plan* itself its true aim was carefully concealed. After 7 chapters with titles like ‘high-quality and personalized care’, a healthier and fitter population’, etc, the radical shift to a market was outlined in its penultimate chapter, chapter 8, under the innocuous title ‘Aligning incentives with patients and professionals’. Chapter 8 announced the introduction of payment by results, spelled out the details of the national tariff, and the operation of market competition including private sector corporations, and explicitly envisaged the closure of NHS hospitals that fail to compete successfully. No MP seemed to have read it. In the brief debate that followed none of these things were ever mentioned.

And so, as Allyson Pollock says in the new edition of her book, *NHS plc*, the final, defining moment in the return to the prewar market-based system was taken with no equivalent of the intense public debate and massive information campaign that accompanied the creation of the NHS almost 60 years ago.⁴ This momentous public policy u-turn is a dramatic example of what political scientists call ‘low-intensity democracy’ or ‘pseudo-democracy’, in which public opinion is focus-grouped, massaged and managed, but not allowed to influence policy.

But then what does determine policy? What is really driving the Blair government's thinking?

The best way to understand it, in my opinion, is as a direct effect of globalization. The key to the government's approach is what New Labour's ideological mentor, Peter Mandelson, called 'the new reality': the situation resulting from the world-wide abolition of controls over the movement of capital in the early 1980s. The 'new reality' created by the freedom of movement of capital meant that all policy must now be acceptable to the financial markets. In New Labour's eyes the proof of this lay in what happened to the party's political risk premium. The political risk premium is the additional interest investors are advised to demand for investing in a country when a given party is in power. In 1992, when Labour lost its fourth successive election, its risk premium was two per cent. A two per cent risk premium is like a massive ball and chain attached to the legs of any government, adding dramatically to the cost of achieving any of its aims. It is also a good measure of the general difficulty it will have in dealing with the private sector, on which it depends for economic growth, employment, tax revenue and the famous 'feel good factor' that is so important for elections.

But by 1997, when Labour finally returned to power as New Labour, its political risk premium had fallen to about half a per cent. Labour got the premium down by abandoning all the measures in its former programme that the City of London most disliked, and adopting some measures the financial markets were particularly keen on – especially giving the Bank of England independent control of interest rates, with a

mandate only to keep inflation down. This too, of course, became part of the new reality. In the spring of 1995 Blair and Brown went on their famous ‘prawn cocktail offensive’, meeting investors and bankers and financial advisers in the City. One of the agenda items at these meetings was the PFI, which had been invented by the Conservatives under John Major but which was not yet ready for implementation. Agreeing to take the PFI forward if elected was, I suspect, another pre-election pledge made privately by Blair and Brown to the financial markets at these sessions.

And then, once Labour was in office after 1997, a further shift occurred – a shift from *recognizing* ‘the new reality’ to *embracing* it. I am no psychologist, but it would obviously be hard to spend a full term in office doing things because you recognized you must, rather than because you wanted to. Most people in that situation would surely find the ‘cognitive dissonance’ involved too much to tolerate. Instead, you would look for things to feel positive about in what you were doing. In the case of New Labour there was no shortage of influential voices encouraging them to do so – from the World Bank and the OECD and the EU and the World Economic Forum to the government’s specialist health advisers, KPMG. And so little by little, and in some cases quite rapidly, the senior Labour leadership stopped seeing private enterprise as a necessary evil, and become enthusiasts for it – often with the uncritical zeal of new converts.

This, then, is the context in which we have to see current government policy on the NHS. The government believes fervently that private enterprise, based on competition, has a built-in tendency to cut costs and increase output. Therefore an expensive public service

like the NHS needs to be subjected to competition from private enterprise. When it turns out that private enterprise is not capable of competing with the NHS, instead of asking what it is that makes the NHS more efficient they agree to pay more just to have private enterprise in there offering so-called ‘contestation’. Once established, they reason, private enterprise will become able to offer real competition. The lack of hard evidence for thinking so is brushed aside. It is a matter of faith.

It is also an electoral matter. The City was once concerned about the PFI. Now that 98 per cent of all new hospital building – and the greater part of all new public building – is being done via the PFI, and the interests of the construction and facilities management industries have been taken care of, the City is more interested in the market for health care providers. Just as the credit rating agencies once saw Labour’s attitude to the PFI as a measure of its market-friendliness, now a key test is its attitude to opening public services to private enterprise. There is a potent free trade dimension too. The WTO, of which Britain is a member, is mandated to reach an agreement obliging all signatory governments to let private providers from anywhere in the world bid to provide all public services, including health services. A powerful lobby, inside the EU, which instigated the abortive Bolkestein directive, is pushing in the same direction. All government policy is supposed to contribute to Britain’s export competitiveness, and health policy is no exception. The Department of Trade and Industry looks on the NHS as a major potential source of export earnings and the Department of Health has created a special unit, DH International, to promote the export not just of British drugs and medical technology, but also the new relationship between the NHS and the private health-care industry.

It is in this wider context that we must understand the government's current emphasis on 'choice'. At first sight it flies in the face of common sense. It also contradicts the findings of the government's own National Consumer Council. In 2003 the NCC conducted a survey which showed that 'choice' was not only not a priority for people in relation to public services: it didn't feature in their thinking at all. As one respondent, a so-called opinion leader, said: '[When we ask people] choice isn't discussed. That has not been a theme. Of all the quotes I've ever seen they've never talked about that.'⁵

And why should they? People don't want to have to choose between hospitals, any more than they want to choose between post offices or fire brigades. What they want is that their local hospital should be very good. It is also interesting to note that other government research shows that people who use public services are highly satisfied with them. In surveys conducted between 1998 and 2002, 91 per cent of service users said they were very or fairly satisfied with their GP, and 76 per cent with NHS hospitals; and significantly enough, service users who were older or from deprived backgrounds were more satisfied still.⁶

I wonder how many private services are equally well liked. I have not found any comparable data for private sector services but it is worth mentioning that last year, when the BBC took a look at the ten services people most complain of, the only public service on the list was the railways.⁷ The least satisfactory services of all were those of banks.

But the emphasis on choice makes sense in two other ways. First, it steals one of the Conservatives' favourite items of electoral clothing, by appealing to middle-class consumerism. But, second, and above all, the government believes that patient choice – something people don't want – will give them something they do want, or at least should want: better hospitals. In other words, the government does not really see 'choice' as a gift to patients. What it thinks is that hospitals must be made more efficient by having to compete for patients, so patients must be induced to choose between them. There is in fact no good evidence for believing that competition makes hospitals more efficient, even in a business sense; and even if there were, it is important to remind ourselves that competition doesn't typically make weak competitors stronger, it makes them go under. The most likely effect of competition for people whose local hospital is already weak is that it will get worse.

And whether being more efficient in a business sense would mean that hospitals were better for patients is of course a different question again.

Nonetheless we are going to see a competitive quasi-market introduced. But it will not be easy, as the financial problems now being experienced by NHS trusts are already demonstrating: half way through the biggest increase in spending in the NHS's history two-thirds of them are facing deficits and contemplating service cuts. The conversion of any public service to a market is especially difficult in health care, and not only because health services are such a sensitive issue.

There are four necessary conditions for the privatization of a public service, and each of them is much harder to meet for health services than for any other public service I can think of. They are 1) it must be possible to package the service into discrete units with known costs which can then be priced for sale; 2) the public must be induced to want to buy what it has been used to getting free at the point of delivery; 3) the government must underwrite the risks of private capital to get it to enter what is initially still a largely unknown market; 4) the workforce must be converted from one motivated by a professional service ethos to one based on making profits for shareholders.

A few years ago I did a comparative study of the marketisation process in public service broadcasting and in health care.⁸ It was very clear that in the case of health care every one of these conditions is very much harder to meet. Packaging health care into discrete treatments is in all circumstances arbitrary, and in the case of chronic and interacting diseases, virtually impossible, whereas packaging and pricing TV programmes presents few problems. Making people willing to pay by reducing the quality of what has hitherto been offered free at the point of service – as happened, for instance, when BSkyB was allowed to get a monopoly of live premier league matches – is politically unpopular when it comes to health services, and can't be done – at least for now, in Britain – when it comes to treating major illnesses or accidents. Covering the private sector's risk in entering the new market is also expensive, and the cost of this comes out of tax revenues and so is, again, unpopular: the costs of the PFI are a case in point, as is the special tariff now being paid to the companies operating the ISTCs. And, finally, health service

workers have a much stronger public service ethic than broadcasting workers, and are not so readily converted into employees working to make money for shareholders.

But this isn't to say it can't be done – that the NHS cannot be, in effect, replaced by a tax-funded private market. It would be a big mistake to believe that the role of the private sector in the NHS will be limited to one per cent of the NHS budget, or any other particular percentage, as Ms Hewitt implies. To believe this is to underestimate the power of today's transnational corporations relative to today's state – a state that is being drastically 'hollowed out' in the name of 'the new public management'. The DH is a signal case in point. Having got rid of all the accumulated skills of its regional offices, it is now clearing them out of its core offices. In his excellent essay on *Post Democracy* Colin Crouch puts the result in a nutshell:

As more and more state functions are sub-contracted to the private sector, so the state begins to lose competence to do things which once it managed very well. Gradually it even loses touch with the knowledge necessary to understand certain activities. It is therefore forced to sub-contract further and buy consultancy services to tell it how to do its job. Government becomes a kind of institutional idiot, its every ill-informed move being anticipated in advance and therefore discounted by smart market actors.⁹

Given the central role in DH policy-making now played by skilled operators seconded in from the corporate world, it is naïve to think the newly-confident and expanding private

sector that is now being installed, as Chris Ham acknowledged, as ‘an increasingly major part’ of the NHS, will not to try to advance its full agenda. To suppose that it will remain content with one per cent, or even five per cent, of the NHS budget is to imagine that healthcare companies are exceptions to the rule of corporate life that we see illustrated every day in the business pages: the rule that shareholders get rid of chief executives who fail to deliver a steadily increasing share price, which is closely related to market share.

So how will the difficulties be overcome? The obvious way forward is the one that has already been pursued so successfully for 25 years – incrementalism. An obvious next step, for example, is the introduction of user fees or ‘co-payments’. Mr Reid said this would never be done. But it has already been done for prescriptions and dental services, and it is very much on the agenda of the leading advocates of the restoration of a health care market, in think tanks like Civitas and the Social Market Foundation, and in the Conservative Party. It even found its way into an early essay by Prime Minister. Its fundamental appeal is that it allows those who can afford it to buy ‘superior’ or ‘enhanced’ care, without having to pay, through taxes, to ensure that everyone else has equally ‘superior’ care. It also has a class appeal to those who don’t appreciate being treated in hospital in the same way, or in the same ward, as their cleaning woman. With 13 million people already enjoying some form of private medical cover, it would not be a radical departure to introduce user fees – initially modest fees – for a wide range of services, from GP consultations to so-called hotel fees for inpatient stays.

As the power of the private health care industry builds up, it seems to me rather likely that this idea will start to be more actively promoted, especially as the long boom comes to an end and government revenues become less buoyant. The government – any government – as well as the foundation trusts and the private providers – will be urgently seeking new sources of funding. Moreover patients will once more be open to the idea. As the market takes effect, the destabilization of hospital services leading to service cuts and job losses will begin to affect all services and staff morale. Instead of long waiting times for elective treatments, other shortages and shortcomings will appear. The incentive to buy protection from all this will resurface and the private healthcare industry is focussed very sharply on devising more and more forms of fee-paid ‘enhancement’ to tempt us with. I will be pleasantly surprised if the government’s declared opposition to user fees is not one of the next ‘old Labour’ values to be ‘modernized’.

A similar value shift could, apparently, also affect the public service ethos of the NHS workforce. I am particularly thinking of health care professionals. In his excellent book, *Decline of the Public*, David Marquand argues that professions are a defining characteristic of the public domain. ‘The public domain’, he writes,

as it developed and grew in the nineteenth and twentieth centuries was quintessentially the domain of... professionals. Professional pride, professional competence, professional duty, professional authority and, not least, professional career paths were of its essence. Professionals were the chief advocates of its growth; they managed most of its institutions, and the policed the frontier

between it and the adjacent private and market domains. Above all, the values of the public domain were their values.¹⁰

Professions are distinguished from market-based trades, he argues, because the principle of *caveat emptor*, buyer beware, which is fundamental to the market, cannot work in fields where the client cannot judge the quality of the service – except when it is too late. We put our trust in professionals on the basis that they control entry into their profession and ensure that all its members have the expertise they should have, and that they have internalized a set of norms that preclude them from abusing their monopoly position and, in Marquand's words, 'enjoin them to promote the public good'. 'This, in turn,' Marquand argues, 'means that professionalism is, in a profound sense, not just non-market but anti-market'.¹¹

But how true is this? Presumably the 300-plus NHS consultants who the Iranian businessman Mr Ali Parsa claims have signed up to be partners in his new chain of private hospitals do not agree. It will be interesting to see how far their alleged enthusiasm for making a profit out of medicine, on top of both their NHS salaries and their fees from their private work, is representative of the medical profession as a whole.

In this context I would like to draw attention to the Canadian Medical Association's decision, by a two-thirds majority at its annual conference in August this year, to support the introduction of a private health care system in Canada, which is at present effectively illegal under the Canada Health Act. In Canada this is referred to as creating a 'two-tier'

system, such as we in the UK already have. I wonder if two-thirds of the members of the BMA would now vote for two-tier health care *within* the NHS. I like to think not. I would like to think that in Britain the medical profession is still identified with the provision of a universal, comprehensive and free service and that this will pose a significant obstacle to the reversion to a market system.

For the fact remains that in health care our dependence on professional expertise is greater than ever, and in spite of all the attacks that have been made on the medical profession in recent years, the evidence of survey after survey confirms that doctors remain the single most trusted group in British society.¹² Their potential to influence public opinion remains very great, and they are uniquely qualified to explain and defend this dimension of the public domain. From this point of view, the medical profession in England is faced with a historic opportunity and, I think, duty.

This may well sound a bit portentous. But there is a profound sense in which the principles of the original NHS are not just important in themselves, as a matter of social solidarity, and the rational use of our collective resources. They are also integral to democracy – not the pseudo-, low-intensity kind, to which we are becoming increasingly habituated, but one where the state is really responsive to the wishes of an informed electorate. For that to be possible, ordinary people must feel a degree of security and independence from the rich and powerful. This has always been problematic, because modern society has almost always been highly unequal. But the welfare state represented a huge advance in this respect. Even today a voter without a job, and without a decent

education, can still be confident that his or her family will be protected, as much as anyone can be, from illness and pain. To meet this elementary need he or she need not be deferential to a boss or a political patron, or to charity. This is not a small thing.

‘Freedom from fear’, as Bevan called it, is a crucial element in what makes democracy more than a charade; and the electorate’s consistent support for the NHS rests, I believe, partly on an awareness – no doubt a mostly subconscious awareness – of this. That is why I also believe that a robust defence of public health care by the medical profession now could trigger a public response capable of halting and reversing the semi-secret plan to re-privatize health care on which the government is currently embarked.

¹ *The NHS Improvement Plan: Putting People at the Heart of Public Services*, Cm 6286, 2004.

² Nicholas Timmins, ‘Election 2005’, *The Financial Times* 19 April 2005.

³ *House of Commons Debates*, 24 June 2004, col. 1454.

⁴ *NHS plc: The Privatisation of Our Health Care*, London: Verso, second edition 2005, p. 238.

⁵ *Expectations of public services: Consumer concerns 2003*, National Consumer Council, London, February 2003, p. 11.

⁶ See *Monitoring Satisfaction: Trends 1998-2002*, People’s Panel Final Wave, The Prime Minister’s Office of Public Services Reform, London 2002, cited in *Expectations of public services*, p. 7.

It is also worth noting that when people were asked, as members of the general public rather than as service users, how satisfied they were in general with the NHS, only 58 per cent said they were fairly or very satisfied. Even allowing for the inclusion in this sample of those who were non-users of the NHS, this is a significant drop compared with the level of satisfaction with the services people had actually used. It means that many people who are satisfied with their experience of the NHS nonetheless say they are not satisfied with the NHS. This apparent paradox is attributed to two things: constant hostile media stories and rising expectations. Thus people are satisfied with their treatment, but still feel it could somehow be better.

⁷ ‘Brassed Off Britain: which ten things brass Britain off?’, <http://www.bbc.co.uk/bob/>

⁸ *Market-Driven Politics: Neoliberal democracy and the public interest*, London: Verso, 2001.

⁹ Colin Crouch, *Post-Democracy*, Cambridge: Polity Press, 2004, p. 41.

¹⁰ David Marquand, *Decline of the Public*, Cambridge: Polity Press, 2004, pp. 53-54.

¹¹ *Ibid.*, p. 55.

¹² See e.g. the MORI poll for the BMA, March 2005: <http://www.bma.org.uk/ap.nsf/Content/MORI05>