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THE PRELUDE TO TODAY'S NATIONAL HEALTH SERVICE

THE IDEOLOGICAL, POLITICAL AND ECONOMIC CONTEXT FOR THE PUBLIC SERVICES IN BRITAIN

This chapter will examine those significant precursor events that shaped the environment in which the present-day NHS exists. In doing so, this will also locate the NHS within the overall provision of public services for the nation.

THE REASONS FOR THE WELFARE STATE IN BRITAIN, 1948–70

Any attempts to study the workings of the welfare state require careful consideration of its history as well as a rigorous analysis of its strengths and weaknesses. The welfare state in Britain, of which the NHS is a major and enduring part, is complex. It originates from the Beveridge Report, which was the major plank of post-World War II social reconstruction (HMSO, 1942). The report provided a set of welfare principles for improved social justice for British citizens. It thus paved the way for a legislative framework to tackle five areas of serious need that the report had identified (Timmins, 1996). These were:

- want;
- disease;
- ignorance;
- squalor;
- idleness.

In embarking on this ambitious task the first post-war Labour government assumed full state responsibility for vast areas of human well-being. It did this in the ideological belief that market competition could not deliver services for people and meet vital areas of human need. The market economy had failed the population in the inter-war years when much of it experienced unemployment, poverty, poor educational standards, poor health and poor housing. Market forces had failed to supply these important social goods and to deliver essential services. The government thus felt that large-scale, collectivist state intervention was required to meet this unmet need and that only this mechanism could effectively and fairly deliver the volume and quality of services that were required by the post-war population. Its doctrine rejected the market system that had preceded World War II as morally divisive because of its emphasis on the individual and especially on individual acquisitiveness. Total reliance on market exchange as the basis for providing welfare had produced a nation that was socially divided through the unfair way in which it distributed opportunities to its people.

These early social policies on the relief of need were based on citizenship theory (Titmuss and Morris, 1973, 1976; Andrews, 1991). This argues that although at a fundamental level the welfare state provides a necessary safety net, it is also a desirable thing for moral reasons. This line of thinking contends that the welfare state:

- relieves the effects of poverty and other dire forms of social need and protects the most vulnerable people in society;
- lessens social inequality through redistribution of the national wealth from those who have a comfortable standard of living to those who have not;
- promotes an ethically conscious society in which citizens are prepared to contribute willingly through various forms of taxation towards services that they do not often use themselves;
- contributes to the development of individual character and makes each person a more responsible citizen;
- lays the foundation for shared beliefs and values that strengthens communities through a common morality and a consensus on what is right and what is wrong.

The welfare state is a by-product of a strong economy and of economic growth. In order to achieve its ambitious social policy intentions the 1945 Labour government needed an economic policy that would make its plans affordable. The natural ally to Beveridge's welfare policy was the economic theory of John Maynard Keynes (Keynes, 1973; Stewart, 1993). This

theory provided a stark contrast to the economic thinking that had preceded it. Keynes's ideas provided a replacement strategy for a system that stemmed from the late 18th century that had its origins in the work of Adam Smith (Fry, 1992).

Smith's principles had thus been the predominant determinant of economic activity for over 250 years. These principles adhere unswervingly to free markets where a system of exchange (based on the price mechanism) distributes all goods and services, including those public services that the welfare state was intending to provide. The doctrine supports a view that the individual is paramount in the process of exchange that is based on vigorous competition. An underlying assumption of this market economic theory is that state interference in the economy is inferior to letting individuals make economic judgements for themselves. Within this thinking, individuals are believed to be naturally selfish, and it is only by encouraging them to operate out of personal self-interest that they will optimise their personal gain from any transactions in which they are involved. Competition, therefore, is the major motivator of rational economic behaviour within this system of market exchange and it is believed that its efficiency stems firstly from its capacity to reward the most successful who survive and prosper and, secondly, because it also forces the weakest and most inefficient competitors to go out of business.

The policies originating from Beveridge's view of the world clearly needed to radically modify this former free-market orientation. What Keynes advocated to afford his bold macro-economic plan for welfare reform required unprecedented state intervention in the management of the economy. This economic plan ran in parallel to the way the state intended to intervene so extensively to provide new types of public services. Put simply, Keynesian economics ensured that:

- State intervention in the economy secured full employment.
- The government had to intervene to control interest rates, taxation policy and public spending.
- The government had a responsibility to stimulate economic growth and to control and create jobs. In practice, this was achieved by substantial state ownership of most major industries.
- The outcome was improved productivity, increased exports and better wages for more people with an overall redistribution of wealth amongst the population.

This way of managing the economy gave way to post-war regeneration and an exponential improvement in living standards for the people. Throughout the 1950s and 1960s both Conservative and Labour governments remained

committed both to Keynesian economics and to the expansion of the public services, and all of this was possible because of the strong economy that was both generated and sustained. The population thus experienced a generalised prosperity and had access to a new range of consumer goods and saw no reason to change. The vast majority of British people became better fed, better housed, had better hospitals and schools, and enjoyed benefits that they had never formerly contemplated.

THE 1970S AND ORIGINS OF DISSENT ABOUT THE BRITISH PUBLIC SERVICES

While the British economy remained relatively strong, all shades of political opinion were totally committed to a welfare state that was fuelled by these Keynesian economic policies. But the 1970s were to see a dramatic change in attitude towards both the economy and, more especially, towards public expenditure and the way in which public services were funded. Periods of alternating inflation and economic stagnation began to take their toll politically. During inflationary times, goods became more expensive and were less affordable at home and were more difficult to export. For the first time in post-war Britain, economic recession began to be experienced and the economy became stagnant, economic resources to pay for the public services were scarce and this resulted in service shortages. All of this was compounded by the rising expectations of an electorate that had become accustomed to nothing other than growing and improving levels of public services.

The Labour and Conservative governments that ruled during the 1970s were frequently under pressure from the trade unions for demands for better wages and improved working conditions. Both governments therefore were pressurised into promises that they could not keep. Neither they nor employers succeeded in managing the coercion from trade unions. These powerful organisations used their bargaining power in the public and private sectors of the economy and made wage claims that the economy just could not sustain. The economic triumphs of the 1950s and 1960s were thus succeeded by steep economic decline in the British economy (Johnson, 1991).

By the 1970s the state also found itself in possession of a range of public services that over a 30-year period had become increasingly extensive and sophisticated. At the foundation of the welfare state it had been intended to provide public services to meet a range of basic human needs. But these service organisations such as the NHS had burgeoned into massive, almost monopolistic, institutions that began to provide far more extensively than

had been envisaged. The remit for services thus extended beyond meeting basic needs to catering for the complex personalised requirements of the population. Therefore, it was only when the economy became unable to pay adequately for this plethora of public service institutions that a new powerful debate about them began. The arguments that emerged were based on two principal propositions that concerned the entire intellectual rationale for the welfare system. These included:

- The ideological beliefs that the welfare state was devised for a former era and that its services were irrelevant to a modern capitalist economy and therefore needed a drastic overhaul.
- Economic arguments to accompany this dogma that suggested that Keynesian economics had not managed to halt Britain's economic decline and were in similar need of refurbishment.

Much of this new debate emanated from the opinions of what was to become known as the 'New Right' (Loney, 1987). Its dogma accompanied the election of Margaret Thatcher's Conservative government in 1979. This movement stimulated a new creed and initiated a continuous set of deliberations that remain very alive and are unresolved to the present day. These consist of a trenchant critique containing political, economic and moral components about the overall ineffectiveness of the collective action that had given birth to and sustained the public services.

In ideological terms the welfare state and the British system of public services are seen by the New Right to be based on false assumptions. The idea that the state should attempt to provide equality of opportunity between individuals is regarded as an infeasible aspiration because it is held that individuals cannot be made better off or be improved morally simply by giving them a set of state-funded rights and entitlements. In essence, the New Right issued a rebuttal to conventional post-war thinking by openly declaring the notion of social justice to be an ethereal concept that is as impractical as it is unattainable.

The public services thus became branded paternalistic because they act on behalf of the individual in too many ways and had begun to assume responsibility for multifaceted aspects of people's personal lives. Such views argue that Britain's vast public service machinery constrains individual liberty through the lack of choice within the services that were available. State services came in a standardised form and alternative options to them were rarely available. Furthermore, it was argued that the extent of state involvement in the lives of individuals renders them passive, suppressed individual initiative and created a culture of dependency.

The New Right argue that, in realistic terms, there is no evidence that the welfare state has produced a more equitable and caring society; rather, that it has produced an underclass of individuals who are unable to act for themselves. This is evidenced as the welfare state's abject failure to deal with inequality and, furthermore, is believed to have created some of the very problems it set out to alleviate. Evidence proffered for this can be found in cases such as those people who are unemployed, who are caught in an earnings trap and are financially better off by living on state benefits than they would be in low-paid work.

The solution to all these criticisms is seen to lie in the return to a system that openly acknowledges that, first and foremost, relationships between people in a capitalist society are economic. What the New Right sees to be required is:

- The re-establishment of belief in the individual citizen as the focal point for political, economic and moral reasoning. This is necessary because the state cannot possibly assume collective responsibility for all of its individual citizens. Nor can the state identify what is the common good and then maintain the entitlement of individuals to a share of it. This gives way to claims that there is no such thing as society, only individuals.
- The reinstatement of the market principles of Adam Smith as a paramount requirement by allowing individuals to judge their own needs and wants. This concerns adherence to the laws of supply and demand and the primacy of free competition that must be unhindered by government interference.
- An emphasis on the individual as the sovereign consumer of goods and services. Consumers should be enabled to exercise free choice between commodities by expressing personal preferences through their personal spending decisions. It is believed that public services should be treated no differently from other consumer goods available in everyday life and that service users should be able to exercise the same sorts of judgements in acquiring, for example, their health care, as they employ when they purchase groceries.

THE ECONOMIC SYMBOLISM OF THE CONSERVATIVE YEARS, 1979–97

The 1979 Thatcher government initiated a train of events that continue to dominate economic policy and indeed much thinking about the way in which state welfare is provided both presently as well as in the future. The Labour government of the latter 1970s along with Keynesian economic

policies began rapidly to lose their credibility with the electorate. There grew a broad agreement and a common feeling that far-reaching change was needed in the way the economy was managed and in the way that the country should be governed. Margaret Thatcher was elected in 1979 on a broad range of issues that aimed to restore public confidence in democratic government. The ideological starting point for the first administration was the strident resurrection of a set of traditional values that were reminiscent of the rhetoric of Victorian times. These emphasised the salience of such things as the significance of law and order and the institutional value of the family. All of this had a superficial attractiveness that appealed widely to the people because it appeared as an antidote to what many had previously perceived to be feeble government.

A new Conservative government brought with it a fresh economic policy that saw the introduction of the dogma of monetarist economic theory. As a consequence and as an adjunct to this, fresh thinking began to occur on the proper role of government in relation to public services as well as about the ways in which these should be paid for and delivered (Masich, 1983).

Monetarism was therefore adopted wholeheartedly and it remains the prominent mechanism for controlling the British economy; its introduction led to the rejection of the previous Keynesian approach to macroeconomic management. Monetarism argues that Keynesian economics had resulted in governments' interfering excessively with free-market exchange. The quest for full employment, high public expenditure and overall economic growth that had succeeded during the previous 30 years was seen to be failing substantially. Keynesian methods of managing the economy had produced high taxation but not the full employment or the economic growth needed to pay for ever-expanding public services. Monetarists argued that the approach had created high price inflation that was destroying the prosperity the people had come to expect. This was blamed for eroding the value of their personal savings and for suppressing the working capital of businesses.

Monetarism, or the quantity theory of money holds that:

- The key to economic growth and improved prosperity and better living standards relies on the control of inflation.
- This requires the Bank of England to strictly control the supply of money in circulation so that it does not exceed the expected growth in output. This requires careful economic forecasting so that the country lives effectively within its means.
- Monetarism contains the in-built supposition that management of the economy should not artificially maintain full employment and that

only economically sustainable jobs should exist. This is at variance with the former job-creation strategy that accompanied Keynesian economic thinking.

- Unemployment is therefore intended to find its own level. This belief from the early 1980s to the mid-1990s produced distress, and unemployment was believed necessary in the medium term to restore normal trading relationships with the rest of the world. These relationships were to eventually support the fuller employment that was indeed enjoyed at the end of the 1990s and at the commencement of the 21st century.

The political attractiveness of monetarism concerns its seeming simplicity (Johnson, 1991). When the Conservative government first introduced it in 1979 it starkly confronted those previously combative trade unions by presenting an option whereby they either accepted the level of wages that were on offer or faced the prospect of unemployment. Monetarism also provides a response to the accusations of state paternalism that are advanced by the New Right. It achieves this because it reduces overall political interference in the economy that requires only a light touch from the government of the day. The doctrine also finds wide acceptance with financial institutions because of the power it gives to them within the overall economy.

THE CONSERVATIVE YEARS AND THE MANAGEMENT OF THE PUBLIC SERVICES

The years between 1979 and 1997 saw continuous Conservative government that was steered politically by the ideology of the New Right and economically by monetarist economic theory. This represented an era marked initially by the reform of the previously unaccountable trade unions through legislation that limited their powers to disrupt British industry. The early part of the period was characterised by growing unemployment that began to weaken the formerly confrontational trade unions. A principal objective of the Thatcher administrations during the 1980s was to privatise government-owned industries. This was portrayed as the reduction of a burden on the taxpayer, a decrease in government interference in the way the country was run and a reduction of government intrusion into the lives of individuals, by enabling them to contract freely with private operators rather than being passive recipients of state services. The privatisation of large government-owned industries was accompanied by the flotation of shares in the newly privatised companies that also gave the people a notional new stake in the nation through the opportunity to become shareholders.

The 1979 Conservative government displayed a deep scepticism about state ownership in general and the welfare state in particular. It saw its task as one of reducing government intrusion in the economy wherever possible with the promotion of an enterprise culture where private ownership could flourish. While it was possible to attract capital from banks to privatise the more lucrative-looking state-controlled industries such as British Airways, the gas and telephone industries, some institutions of the welfare state were by no means as attractive to the owners of private capital.

CONSERVATIVE GOVERNMENTS AND THE NHS

The NHS is a prime example of a monolithic organisation that remained relatively unappealing to private capital and private investment. It is the largest employer in Europe with 1.3 million employees, one of the biggest employers in the world (Morris, 2003). Its building stock is very varied in its quality and some dates from the 19th century. The performance of its key functions, though consistently high, are very vulnerable to criticism in part because the NHS is so highly politicised. Although the post-war governments of both major persuasions have behaved in similar ways towards the NHS, each finds it possible to construct highly negative political capital about it when in opposition. These factors rendered only selective parts of it attractive to prospective private investors or buyers.

It can be seen that the NHS and most welfare state institutions therefore were not candidates for privatisation because their business is unpredictable and their environment is uncertain, and indeed risky, when judged by most common commercial criteria that concern profit and loss. Yet the NHS is a major cause of public spending. So its performance was highly significant to Conservative governments that had been elected on pledges to lower personal taxation and to lower public spending on services it saw to be inefficient. Solutions had to be sought. Although privatisation would have been the method of choice, compromises had to be sought during the Conservative years. Three major strategies were employed:

- a wholesale commitment to private provision;
- the use of contracting-out and of creeping privatisation strategies;
- the creation of quasi-markets or internal markets.

PRIVATISATION

The Conservative administrations between 1979 and 1997 were committed to the extension of private provision of public services wherever this

seemed economically possible and politically feasible. Notable examples include the subsidised sale of council housing. The pretext was that this would increase the number of owner-occupiers, who would take better care of their properties once they owned them that in turn would improve the housing stock and create the moral bonus of a property-owning democracy at the same time.

Private medical provision was also encouraged. Previous restrictions that required public consultation before a private hospital could be built were abolished and this saw a growth in private hospital provision. The key to private health care is private medical insurance and this saw a steady increase in subscribers that was most dramatic in the late 1970s and 1980s and achieved stability in the 1990s (ONS, 2002). A low of 2.1 million who were insured in 1971 grew to 6.9 million in 2000. This rise was entirely due to company-paid business because the number of individual private medical insurance subscribers fell between 1999 and 2000. This occurred because the Conservative Party gave tax allowances to retired people who had a health insurance policy in their former employment as an encouragement not to let their policy lapse once they ceased to work. New Labour, however, removed this when it was elected in 1997, causing many policies to lapse.

Hospital land sales and the sale of other unused assets also commenced to generate new forms of income from private sources. These income-generation projects ranged from the sale of redundant mental hospitals and other surplus land to the introduction of car parking fees at hospitals and the leasing of retail outlets in the foyers of NHS hospitals.

CONTRACTING-OUT AND CREEPING PRIVATISATION

Conservative governments also introduced the creeping privatisation by picking off those parts of the public services that were amenable to private competition. This was in harmony with the Tory view that the state might have an enduring responsibility to foot the bill for providing a particular service. That said, it need not necessarily remain a monopoly provider of it if a private organisation was able to compete against a traditional state-managed provider to deliver a superior product. Hotel services in hospitals were an early example of this principle where competitive tendering was introduced between in-house teams of cleaners, caterers and porters and outside private providers.

The privatisation of the long-term care of elderly people is a further example of how government relinquished its responsibility for providing intermediate and long-stay services but was willing to largely pay for the private sector to provide them. Historically, the state had a range of provision for the long-term care of elderly people. This consisted of NHS

geriatric hospital and psycho-geriatric hospital provision and elderly care homes run by local authorities. The 1980s saw a move to privatise this type of care in old age as far as and wherever possible. Dedicated hospital beds were reduced and geriatric hospitals and the psycho-geriatric facilities were closed. Patients were transferred to rest homes and the state pension and benefit regulations were amended to make elderly people's benefit entitlements available to pay for their residential home and nursing home care. Means testing was introduced and those elderly people with assets began to have to use their savings and, in some cases, sell their homes to fund care that had been provided previously by the state. Similarly, local authority homes were sold off or closed and their residents transferred to the private residential home sector. A new definition of care known as 'social care' appeared for which it could be argued was a euphemism for those aspects of care for which individuals with means would be charged for what, formerly, were free public services.

QUASI- OR INTERNAL MARKETS

The White Paper *Working for Patients* paved the way for the NHS and Community Care Act 1990 and initiated the idea of the internal market in health and social care, and this impacted on the NHS and on local authorities (DOH, 1989). The key feature of this arrangement is the purchaser/provider split. Central to this means of dealing is the idea of contracting. The elements of the contract are that:

- a provider agrees to deliver for the purchaser a particular volume of service;
- at a particular price and quality;
- by a particular time.

Under this system local authorities became purchasers of social care and health authorities became purchasers of hospital care and treatment. Local authorities were compelled to purchase care from providers who were either profit-making private care organisations such as residential homes, or from the increasing number of non-profit-making charitable organisations. These latter organisations proliferated to plug gaps in public provision for groups like the former residents of long-stay mental and learning disability hospitals.

Health authorities had originally managed their local hospitals as well as purchasing the care for them. The internal market created a new set of relationships. Health authorities became purchasers and hospitals became providers and were given a new semi-autonomous status by being designated as NHS trusts. In reality, despite some freedoms such as the limited

right to raise private capital, they remained subject to stringent government controls.

This method of internal market organisation was meant to mimic the operation of free commercial markets and to do so within services that were to remain largely state financed. Organisations like the NHS and local authorities had always understood what their total annual cost was. What was new about the internal market was the requirement to determine the detailed price of individual elements of service: for example, the price of an individual surgical operation. Having detailed pricing information was an essential prerequisite to the development of the quasi-trading relationship and to the introduction of the notion of competition into the public services. It is the price mechanism that powers those free commercial markets that the public services were intended to emulate; this can be understood at its basic level as follows:

- the spontaneous demand for a commodity or a service will produce a price rise;
- a price rise will usually give providers of a service an incentive to increase their profits so this stimulates extra production;
- extra production results in the relief of scarcity;

To transfer this last analogy to the NHS it can be seen that:

- a spontaneous rise in the number of patients needing hip replacement operations should stimulate an NHS trust to be able to ask a higher price because of the demand;
- orthopaedic teams in the NHS trust should therefore have an incentive to operate on more patients to increase their income and hence their profit;
- the increased surgical activity should mean that the waiting list for hip replacement should be reduced thus reducing the scarcity of care for the procedure.

This over-simplistic explanation tells little about the true complexities of advanced capitalist economies. Yet free-market thinking contends that a system of exchange on the basis of an agreed price maintains its own equilibrium and allocates resources efficiently. At one level, therefore, the rationale for internal markets in health care stemmed from the ideology that central government-driven decisions are inferior to private individual decisions in delivering public services. The argument goes that markets behave spontaneously and are capable of reacting more rapidly to changing need within public service organisations than the traditional funding methods

used by local authorities or the NHS. It was envisaged that a system of competition would be created between providers that would weed out inefficiency and would produce smooth change within organisations. Strong providers would survive and prosper while weaker providers would wither and go out of business.

THE EXPERIENCE OF THE INTERNAL MARKET IN HEALTH CARE, 1990–97

The idea of an internal market in health care originated in the work of an American health economist Alain Enthoven (Enthoven, 1985). This was translated by the Conservative governments of the 1990s into a working policy and a set of quasi-trading practices designed to improve the delivery of health services through a purchaser/provider split. Another phenomenon, that was not Enthoven's creation, was also introduced that was known as GP (general practitioner) fundholding, whereby some GPs were able to purchase care directly from NHS trusts. The core principle in this arrangement was that money would follow the patient, thus giving providers a new incentive to treat more patients. Enthoven subsequently produced an analysis of the effects of these internal market reforms in the NHS (Enthoven, 1999).

The internal market probably did produce more productivity and introduced a culture of more business-like cost-consciousness into the NHS but its success was limited by a number of crucial issues. Competition, which was intended to be economically more efficient, produce higher quality services and send the weakest providers to the wall, did not flourish, because the infrastructure for these things to occur did not exist. Other handicapping factors were as follows:

- To produce competition required a large investment in information technology, contract managers and accountants. This generated higher administrative costs that were compounded by a convoluted, bureaucratic and expensive system of invoicing that impacted negatively on the financial benefits of improved productivity.
- The market information and details of pricing needed to produce genuine trading relationships was poor, resulting in weak market forces.
- Pricing information lacked transparency so that competing providers did not have access to the prices of their rivals.
- Health authority purchasers or GPs acted as a proxy for the patients. Patients therefore did not have the information to make rational economic decisions about their care so that the true notion of consumer choice failed to develop.

- Purchasers continued to buy from their local supplier as they always had done and there was little evidence of them shopping around for the best buy.
- For some NHS trusts in geographically remote parts there was no one with whom to compete. Something resembling a competitive market was possible in large cities that had more than one provider but the Conservative government managed competition because it was afraid of the political controversy that might result if particular services that were cherished locally had to be reduced or closed.
- NHS trusts had such low reserves of working capital that it would have been easy for a large GP fundholder to destabilise the market simply by moving business from a local hospital to a provider elsewhere. This was a further reason for government to manage the internal market.
- Patients followed the contract, rather than money following the patient, and contracts were rarely removed from weak provider trusts so that even seriously failing providers were allowed to stay in business.
- There was the potential for patients of GP fundholders to fare better than those of non-fundholder patients, creating inequities in the access to services.

The Conservative years created an impression that the welfare state was being dismantled. Certainly, attitudes to it changed and so the superiority of totally publicly funded health and social care services was challenged both ideologically and practically. A bigger private element in welfare provision had appeared. Consumerism became the watchword and although government interference in the operational management of services had been strengthened, there was little evidence that individual citizens were genuinely empowered. Attitudes within public service institutions were nevertheless transformed through the values and practices derived from private business that were adopted in the quest for greater efficiency. But rather than being abandoned, the welfare state remained largely intact and changed its shape rather than its fundamental purpose.

NEW LABOUR AND THE CONTINUING DEBATE ABOUT PUBLIC SERVICES IN BRITAIN FROM 1997 INTO THE 21ST CENTURY

New Labour came to power in May 1997 within a public mood resembling that which welcomed the first Thatcher government in 1979. The electorate was reasonably unequivocal that it was time for a change, and the first administration of Tony Blair was given a strong mandate at the

ballot box and his second government was returned to power for a second term in June 2001 with an even greater majority. The size of their electoral lead was such that it potentially gave the second New Labour government the power to create unbridled change. In the course of both terms of office New Labour abandoned, incrementally, many of the party's time-honoured socialist principles concerning collectivist state provision and committed itself to what historically had been the Conservative Party's philosophy. Most notably it stuck to the monetarist doctrine of the Tories and adhered faithfully to its predecessor's policy not to increase personal taxation and to keep spending on public services under control. In theory, New Labour held on to the belief that services such as the NHS should be regarded as a public good to which all in employment are willing to subscribe. At the same time, however, New Labour did not hesitate to maintain Tory market principles and, indeed, in some instances (such as the Private Finance Initiative) it expanded the use of them. This was in direct contradiction to the Party's traditional stance on public services and it has been contended that New Labour became progressively Thatcherite (Warden, 1998).

New Labour's 1997 manifesto contained strong claims that it would abandon quasi-markets in health care. In 1997 it immediately set about doing this in principle, but in reality it left a great many previously created Conservative structures and procedures relatively untouched. In effect it set about coining New Labour terminology for what had been the previous Conservative government's procedures and practices. New Labour claimed to have discarded the internal market in health care. Yet it retained the purchaser/provider split and while allegedly having forsaken contracting, which is the central feature of the quasi-trading process, it actually renamed the deal struck between the purchaser and the provider to be a 'service-level agreement'. By 2003, during its second term, New Labour had not only restored the Conservative internal market model of health care through the creation of fundholding primary care trusts (PCTs) but it had gone far beyond Tory achievements with plans to enable hospitals to opt out of state control.

From an early juncture, New Labour had to acknowledge covertly that the ideology of the welfare state and its system of public services that had been put in place following World War II was becoming difficult to sustain because the demands made upon them were infinite. At the same time it had to appease its traditionalists from the 'Old Labour' tradition on its left wing. There was nevertheless a general acceptance of the typical Conservative Party view that the system of public provision produces a dependency culture. New Labour therefore envisaged that solutions to the deficiencies in public services would be found in the following:

- Remedying social and economic failure that created a dependency culture by reducing unemployment.
- Improving the targeting of services and dealing more strictly with fraud through better surveillance and the enforcement of the rules of entitlement to state services.
- Improved means testing.
- Encouraging greater self-reliance and promoting self-sufficiency.
- Reconciling policies from both the right and the left that were previously seen to be antagonistic through the adoption of its doctrine known as the 'Third Way'. The doctrine of the Third Way holds that it is possible to embrace long-established Labour thinking about social justice whilst simultaneously employing free-market principles to secure its political ends (Blair, 1998).

What emerged was a consensus view from the major parties that these services cannot be sustained in perpetuity in their current form. The public services in Britain have a high political profile and governments of all persuasions have responded typically to service shortages by allocating money to them generously as a means to a quick political resolution. The issue for New Labour, therefore, is simply not one of investment in services but concerns the ways in which modernisation is to be achieved and a long-term strategy fashioned. The key questions to achieve these things concern:

- What is the optimum means of paying for health services in the longer term?
- Who will be the most appropriate providers?

The New Labour government retained its commitment to services that are funded predominantly from the public purse (HM Treasury, 2002a). But it increasingly moved towards the views of the strongest critics of state-funded services in its commitment to notions of choice, competition and privatisation. The views of these critics were typified by the work of the Adam Smith Institute (ASI) whose founding principles can be seen to coincide in some respects with New Labour's public service policies (Browne and Young, 2002). So even if the funding base for health care does not change, the mechanisms of delivery are patently intended to do so.

The ASI is Britain's leading proponent of market economic policies and has played a key role in the analysis and development of public policies through the publication of many influential policy reports. The organisation has been part of a worldwide movement towards free markets and free trade. The ASI's objective is for the public to have options and for there to be open competition between providers. This is the essence of a free market

that is intended to empower ordinary people by giving them the chance to help frame their future by their direct involvement and the expression of choices. It is believed that through consumer choice public services will be redesigned in ways that inject innovation and customer responsiveness into their delivery. The ASI begins from the somewhat extreme position that in its current form the welfare state is pathological (Marsland, 1994). It believes that the welfare state and the public services it provides have:

- become archaic because these were designed for economic circumstances when Britain was an industrial nation that differ from those that prevail in the 21st century;
- diverted money away from economic growth in ways that impairs investment in the economy;
- reduced personal freedom and choice by causing excessive, compulsory personal taxation over which individuals have absolutely no control either over the amount by which they are taxed or over how their contribution is used by government;
- failed to eliminate poverty;
- suppressed personal initiative, stifled independence and prevented individuals acting for themselves;
- created an underclass from which there is no chance of escape;
- resulted in bureaucratic institutional structures that are inefficient and offer mediocre services;
- resulted in state paternalism.

These sentiments support a safety net of services for a small minority but contend that many public services should be largely replaced by private provision in which the prosperous majority would be encouraged to insure for sickness, education and for pensions. It can be seen from such propositions that consumer choice as well as the adequate financing of services is crucial to their modernisation and it becomes arguable that the current state-financed services spend money inappropriately and fail to deliver what the population actually wants (Butler and Pirie, 2001).

So clearly, as a starting point, New Labour sought to ensure services that are available through general taxation but its stance was that it does not need to control every aspect of their delivery. It took the view therefore that public services need to be restructured to accommodate individual preference and that only when alternatives are available so that individuals can express their likes and dislikes will the publicly funded services improve in terms of their efficiency and quality.

Different sources of provision are thus seen to be required as alternatives to those publicly funded services to add variety and give choice

to the consumer. This means that the supply of services could come legitimately from private profit-making organisations, charitable organisations and not-for-profit organisations as well as from existing public providers. In keeping with its Conservative Party predecessors, New Labour believed that competition is the principal feature of such arrangements because by making service users into consumers, they will exert their own vested interests. This will sequentially drive up quality standards. Furthermore, genuine competition stimulates innovation and newer providers have incentives to enter the market with novel responses to old challenges and with a commitment to achieve the highest standards. In the last resort, those parts of the conventional public services adjudged to be inefficient or failing their clientele such as under-performing hospital trusts would be closed or their business put out to competitive tender.

THE NEW LABOUR APPROACH TO PUBLIC SERVICE PROVISION

New Labour occupied an interesting piece of political ground. Until the mid-1990s Old Labour was passionately committed to social justice and the collectivist provision of public services. It vigorously opposed the strategies of Thatcherism that saw an increased role for individual wealth creation and a withdrawal of government from the provision of state services. New Labour retained a notional commitment to social justice but has sufficed to redefine it through the creation of its 'Third Way' (Giddens, 1998). This innovation provides an amalgam of the two earlier doctrines of the Old Left and the New Right. Through the Third Way, New Labour sought to reconcile those two former polarities by embracing notions of the left such as the need for equality, equity and redistribution yet it accepted, concurrently, right-wing mechanisms for achieving these through private market mechanisms (Blair, 1998). Old Labour had been an outright champion of publicly provided services and rejected everything within Tory thinking that advocated the dismantling of the welfare state. By contrast, while supporting public provision out of necessity, New Labour was happy to see the private delivery of services in ways that are perfectly acceptable to the Conservative Party. The 'Third Way' thus provided a doctrine to sustain a new model of service provision that contained a mixed, public and private economy. Three interrelated and overlapping factors constitute its conceptual basis, namely:

- creating consumer involvement and choice;
- stimulating provider rivalry and competition;
- setting standards of excellence.

The Third Way advocates a series of the free-market assumptions about the absence of competition between the existing and potentially new providers of public services. When government agencies purchase public services they usually do so from the top down, beginning with decisions in the spending departments of the government. This secures services that are provided at the same or a similar level of quality for all users who have few or usually no alternatives. The NHS epitomises this position. A patient needing an expert opinion visits a GP who refers the patient to the local consultant and usually no choice is available to the patient. The NHS user gets what is on offer. This state of affairs has been referred to as 'producer capture' because production is dominated by government, the purchaser of the product or, in this instance, the patient forfeits the ability to shop around for a better buy (Pirie and Worcester, 2001). This inevitably means that the interests of central government policy transcend those of service users. Unlike failing private providers, failing providers of public services such as NHS hospitals do not go into liquidation. In consequence, there is really no economic incentive for them to provide anything other than the basic essentials within their standard service (Butler and Pirie, 2001).

CREATING CONSUMER CHOICE

New Labour has thus re-emphasised the Conservative idea of creating scope for user selection within state provision. To date, new notions of consumerism within public services have improved the providers' understandings of user expectations, yet individuals still have no real means at their disposal for changing the essentials of the services they will receive. New Labour thinking therefore argues that users must become consumers. As consumers, choices are made between various producers, and the real consumer strives to maximise the best possible value for money. Consumer sovereignty is the dogma underpinning each transaction whereby opinions and choices of the individual become the paramount concerns of providers. Accordingly, New Labour envisaged a similar model being available within public services whereby users should have options as to where to locate their business. Consumer choice, where funding follows the consumer, gives new incentives to providers, be they public or private, to respond to the needs and wants of those they serve and to appeal to as many of them as possible in order to boost their returns.

STIMULATING PROVIDER RIVALRY AND COMPETITION

New Labour was reluctant to use the term 'competition' to identify commercial rivalry between providers because of its overtly Thatcherite connotations and so it tended to describe it euphemistically as 'contestability'

(DOH, 2003a). In keeping with this tendency to introduce its own lexicon it preferred to refer to 'public–private partnerships' to the more forthright term 'privatisation'.

The competitive element therefore became evident within the spirit if not the letter of New Labour public services policy that emphasised the promotion of a new commercial-style culture (DOH, 2002a). Terminology aside, it is a generally accepted maxim that within free-market trading arrangements businesses exist primarily to make money and to increase the yield of their shareholders. But to do so they must not only respond to the wishes of their clients but must also anticipate their prospective needs in order to provide new, improved products. Commercial organisations, unlike state-provided public services, fend off competitors to secure a market share in order to stay alive in the market place. It is this affinity with the client in the overall cause to achieve greater economic success that New Labour sought to mimic in the delivery of social goods and services. While this cannot possibly provide a true replication of the economic decisions an individual takes when purchasing in the typical market place, it nevertheless provides a template for market-oriented behaviour to which New Labour wished its public services to aspire.

SETTING STANDARDS OF EXCELLENCE

Government acts as an understudy for the taxpayer in providing public services. This means that the taxpayer loses all control over the destiny of a resource that has been earned personally. The government monopolises the distribution of most public services and the place of providers has been secure because they have not had to compete. The internal market in health care in the 1990s envisaged some competition. But poor pricing information and over-regulation by government meant that its effects were limited. This control of provision has meant that it is highly difficult for the benefactor of those services, namely the taxpayer, to evaluate their functioning and their overall value to society at large.

New Labour therefore aimed to reduce dependency and to empower consumers of services through better information. It began this by subtly employing policies that have their origins in decidedly free-market sources of opinion (DOH, 2002a; Butler and Pirie, 2001; Pirie and Worcester, 2001).

Labour's embrace of the thinking that is in tandem with Thatcherism has been demonstrated as follows, through:

- a substantial extension of the private finance initiative (PFI) to build new hospitals and also to upgrade GP premises through local improvement finance trusts (LIFT);

- the use of under-occupancy of private hospital beds to treat NHS patients requiring paying for elective surgery under its concordat with the private sector (DOH, 2002a, 2002b);
- the introduction of NHS-purchased intermediate care to relieve delayed discharges that were provided for elderly people in the privately run nursing home and rest home sector;
- the increased empowerment of frontline staff and a commitment to let them make the vast majority of spending decisions in the NHS through the creation of PCTs (DOH, 2002a);
- the creation of NHS foundation trust hospitals that are independent not-for-profit organisations that are outside the control of the Department of Health (DOH, 2002c);
- the recruitment of private companies from overseas to increase NHS capacity in the provision of diagnostic and elective surgical services (DOH, 2002b).

The next predictable steps were that private sector providers will be invited to take over failing NHS services such as the first failing NHS foundation hospital trust (Butler and Pirie, 2001; Wilkinson, 2003).

TOWARDS THE FUTURE

It can be seen that the dilemmas in modernising public service provision come back to the recurrent debate that is two-fold. Firstly, how will be services be funded and, secondly, how and by whom will they be delivered?

FUNDING THE PUBLIC SERVICES

In the longer term there is a serious debate about the balance between collective responsibility and individual responsibility in providing personal services to meet human needs. This discussion concerns the balance between those things it is reasonable to expect the state to provide and those that the individual might justly be expected to provide from private economic means.

There are some aspects of the welfare state such as unemployment benefit where there is probably little scope for market solutions. But in other areas such as medical insurance and private health care there is the possibility for a more substantial private–public mix of funding sources. There are other models available that combine public and private, payments and insurance in France and Germany that are worthy of further study. This means that if people want different levels of service, for instance, it is possible to top up a basic state entitlement by

using personal savings. Clearly there need to be safety measures in place for the low paid, the poor and those who are uninsurable. Most countries in Europe have shown such systems can work well and with fairness. What is predictable is that a great many services that were funded by the state at the end of the 20th century will probably be beyond its financial means by 2020, given the changing demographic structure and the diminishing number of taxpayers who will be in employment to support a growing elderly population through payment of their taxes.

In the shorter term, governments seem set to have the bulk of public services funded from the public purse (HM Treasury, 2002a; Duncan Smith, 2003). The debate therefore shifts to one about who should deliver them. The New Labour manifesto of 2001 made a clear commitment to reform and rebuild Britain's public services (Labour Party, 2001). The question is one of means rather than ends and this immediately opens up a long-standing argument about the greater use by government of both private financing and the private delivery of public services.

A MIXED ECONOMY IN PUBLIC SERVICE DELIVERY

A balance therefore is being struck between the state and the non-state sectors (Butler and Yarrow, 2001). Little is known about the potential relative contribution of public sector and private sector provision and how these might become synergistic. It is therefore not so much a matter of either predominantly public solutions or predominantly private ones, rather one of deciding what either provides most appropriately and what is best provided in partnership.

What is predictable is that any mention of private involvement in the provision of public services is likely to be interpreted by some as a move to dismantle the welfare state. This assumes that increased private involvement will occur only in the interests of private providers and will necessarily work to the detriment of public provision (Harrison, 2001). What has not been properly estimated is the scope that is offered by the creation of a mixed economy in public services. A mixed economy offers the state the opportunity to convert the users of services into consumers. What seems certain is that the extent of private involvement in provision is merely in embryonic form and seems certain to grow with the potential that the state could, eventually, become merely the residual regulator of the volume and quality of services.

CONCLUSION

This chapter has addressed some of the ideological, political and economic precursors for today's NHS. It can be seen that the consensus on whether public services should be collectively funded and provided has been breaking up gradually for almost three decades. The main debates have been circular in nature with New Labour gradually shedding its old socialist dogma and taking a stance closely resembling that characterising the Conservative governments of the 1990s.

The vast majority of the British public has grown up to have pride in and to wholeheartedly support the institutions of the welfare state and the ethical precepts that underpin it. Arguments that these institutions can be easily reformed are difficult to sustain. Those who support this point of view generally claim it is just a question of money, but that is just the start.

The public service institutions in Britain of which the NHS is the archetype are the last of the central command organisations in existence. In recent times they have been managed by a central government that dictates the minutiae of their everyday activities. This has occurred through a myriad of complicated targets and initiatives that confound even those who are charged to implement them. It can be seen how monolithic institutions such as the NHS might be modernised is an intricate and politically explosive matter. What is certain is that modernisation is needed and governments will continue to introduce untried reforms in the interest of change of which improvement will be a much-valued outcome.

The following chapter will address the modernisation agenda for the NHS that emanates from the time of the 1997 New Labour government.