POLITICS, COERCION AND POWER: AN ANALYSIS OF ECONOMIC FAILURE IN HEALTHCARE SYSTEMS

A thesis submitted for the degree of Doctor of Philosophy

by

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Abstract

This study examines notions of government and market failure in British healthcare by tracking and analysing the changing views of opinion formers. Presenting original data that highlights the attitudes of today's opinion formers towards populist notions in health economics it provides a unique insight into the limits and boundaries of contemporary debate. Significantly, the research concludes that swathes of elite opinion no longer support the National Health Service (NHS) in its traditional nationalised guise.

While opinion formers instead now believe in a much greater plurality of public and private healthcare today's elite not only question the idea of state healthcare but they also remain sceptical of a purist libertarian market. Indeed, in noting that healthcare has always attracted the interventionist attentions of those with state power, the study questions in fundamental ways the meaning of such terms as 'market' and 'private sector'. In highlighting the timeless propensity for medical and health professionals to seek legislative favour, it argues that the world has never actually seen anything resembling a real market in the bio-medical paradigm and its forbears. Healthcare has always been a deeply corporatist venture run in association with a range of mystical, military, religious, or purely political statist elites.

The study begins with an historical overview of healthcare from the military hospitals of the Roman period, through the religiosity of the Middle Ages, the mutuality of the nineteenth century, the statism of the National Health Service and the recent rise of public private partnerships. Examining such concepts as monopoly, consumer ignorance, moral hazard and externality, it also analyses notions of public versus private goods in the context of today's healthcare.

Contents

CHAPTER I

INTRODUCTION

As the twenty-first century dawns, this thesis explores one of the most important issues concerning people around the world, the organisation and delivery of healthcare.

Analysing the opinions of an influential range of British healthcare opinion formers, it seeks to question and explore the dominant paradigm of market failure in health economics. In seeking to clarify and examine commonly held notions of market failure amongst health professionals, politicians and journalists it highlights the intellectual and conceptual environment in which the health policy conversation is popularly cited and bound.

Worldwide health crisis

During the 2001 general election British voters made it clear that health policy was a primary concern. It seemed to capture the public imagination more than any other domestic policy issue. According to a MORI opinion survey conducted in the last week of the election campaign, 73 per cent of voters chose health and the National Health Service (NHS) as their primary issue[1]. Across the developed world a similar story is told whereby the politics of healthcare increasingly dominate electoral debate.

Yet in a sense this is strange given we live at a time of unprecedented wealth, peace and advanced medical technology. It is peculiar that at a time of ever-greater prosperity people seem increasingly disillusioned with their healthcare systems and deem them to be failing when compared to expectations.

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[1] The Times, MORI Political Attitudes in Britain 5 June 2001. Also see: http://www.google.co.uk/search?hl=en&q=Mori+health+poll+June+2001&btnG=Google+Search&meta=

Today, a great deal of literature suggests that across the world, political, regulatory and professional authorities which oversee most health systems are being questioned and challenged by ordinary people as never before.

In America, the problems surrounding healthcare delivery are profound. Away from a large private medical insurance and self-funding market, government provides two types of healthcare system and both schemes face problematic futures.

US federal law requires all states to provide citizens with guaranteed levels of healthcare under the Medicaid program. Here the federal government provides matching funds for millions of – what are popularly termed – underprivileged people.

Today, every US state is required by federal statute to assist those people in need and to help them access a medical care program acceptable to the federal Department of Health, Education and Welfare.

Overall, eligibility standards vary from state to state depending on legislation. However, at the very least, states are required to provide recipients with (1) inpatient hospital care (other than in an institution for tuberculosis or mental disease), (2) outpatient hospital services, (3) laboratory and x-ray services, (4) nursing facility services for those over the ages of twenty-one and (5) physicians' services, regardless of location or treatment.

In addition to this minimum, states can underwrite a host of other services, including physical therapy, dental care, diagnostic, preventive, and rehabilitative services, and the cost of prescribed drugs, dentures, prosthetic devices, and eyeglasses.

The second US healthcare system is called Medicare. It provides medical and care services to the elderly reliant upon state support. Together, Medicaid and Medicare consume more than 7 percent of American GDP and today both programs are facing increasing funding pressure.

With nearly 40 million Americans not covered by private medical insurance and therefore reliant in some way upon Medicaid it is not surprising that healthcare is a contentious issue. US opinion polls consistently demonstrate that the state's role in healthcare is one of the most pressing issues of concern and debate.

Across many parts of America Medicaid, state funded, hospitals are under financial threat. Many are on the verge of bankruptcy, such as Washington's General Hospital in the nation's capital[2].

The financial outlook for Medicare is similarly poor. According to Peter J. Ferra of Washington DC's CATO Institute:

> "Medicare is perhaps the most difficult problem facing the nation. Most of the elderly rely on it to pay for essential medical care they could not otherwise finance. Yet, the costs are skyrocketing beyond the ability of taxpayers to pay them.
>
> "On our current course, by 2010 total Medicare spending will have doubled to about $540 billion. At current tax rates, payroll taxes will cover only 38 percent of those expenses. Medicare premiums paid by seniors would only cover another 13 percent, even assuming they continue to rise at recent rates. By 2030, under the government's own projections, Medicare will cost $2.2 trillion to $3 trillion per year, accounting by itself for 28 percent to 38 percent of the entire federal budget.

[2] Visited in early 2000 by the author.

> "This runaway spending is expected despite severe price controls on Medicare services and treatments that will only deteriorate the quality of care for retirees over time."[3]

In Britain, the National Health Service and its persistent failings have been a primary cause for public concern for some years now. As an Adam Smith Institute report, launched immediately after Tony Blair's 2001 general election victory, pointed out:

> "If a privatized health service had made many of its patients wait for 18 months for their operations, put them on trolleys in corridors when they arrived, given more than a quarter of them an illness which they did not have when they arrived, and confiscated the organs of their dead babies without bothering to seek their permission, or even to tell them, people would have blamed privatization. For that matter, if one of its practitioners had murdered 150 of his patients, or one of its surgeons had removed healthy kidneys instead of diseased ones, or one of its teams had conducted smear tests so incompetently that operable disease was not treated, while healthy women were unnecessarily subjected to distressing operations, all this would somehow have been put down to the reckless pursuit of profits, or to putting shareholders ahead of patients.
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> "...Many of the above horror stories are symptomatic of an institution which has an inadequate relationship with its customers. As with all state-run bodies, there is a tendency for producer concerns (often dressed up as "professional judgement") to dominate over responsiveness to customers."[4]

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[3] Peter J. Ferra, 'Heroic Medicare Rescue', 30 April 1999, CATO Today's Commentary, www.cato.org
[4] Butler, E and Pirie, M (2001) The New Shape of Public Services, Adam Smith Institute, London, p.9.

In Canada, public opinion again seems to be increasingly calling into question the Canadian government's Medicare system in ways that would have seemed unimaginable only ten years ago. For example, in the work *Operating in the Dark: The Gathering Crisis in Canada's Public Healthcare System,* Brian Lee Crowley, Dr. David Zitner and Nancy Faraday-Smith comment:

> "While the operating assumption of the political class seems to be that Medicare is the third rail of Canadian politics ("Touch it and you die"), in fact public opinion seems to be undergoing something of an evolution in respect of the public health care system. In particular, the idea of more private involvement in health care provision seems to be growing in attractiveness as people become better informed about the costs of the public system and its poor performance, and as a general sense of systemic breakdown grows."[5]

In a Compass poll for the National Post[6] Conrad Winn finds that 41 per cent of Canadians now believe that individuals should be free to choose private health insurance so that they can obtain better or at least faster health treatment than at present.

Similarly, in a poll carried out for the Consumer Policy Institute in October 1997 Angus Reid pointed out that 65 per cent of Canadians believe that individuals should have a much greater degree of choice within the healthcare system.

Although there remains significant differences of opinion on what this might mean in practice, how and whether it would cost more or less than the current arrangements, the direction of Canadian thinking is clear. As Canadians increasingly find they are more economically empowered and prosperous so they

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[5] Brian Lee Crowley, David Zitner, and Nancy Faraday-Smith (2000) Operating in the Dark: The Gathering Crisis in Canada's Public Health Care System, Atlantic Institute for Market Studies, Halifax, Nova Scotia, p.6.

[6] National Post, 6th September 1999.

are dissatisfied with the state healthcare system and want more direct control of those areas of their lives that have up until now been controlled by the public sector.

In David Gratzer's seminal work, *Code Blue*, he argues that Canadians are increasingly questioning a system in which:

> "We hear the horror stories every day: hospital hallways lined with patients; long waiting lists for cancer treatment; a shortage of high-tech equipment".[7]

He continues:

> "No wonder confidence in medicare, Canada's most cherished social program, has fallen to a historic low".[8]

In Sweden, state healthcare has been under pressure for some years. With public expenditure and the wider welfare state increasingly under strain, private sector providers such as Capio have recently taken over the running of a number of hospitals particularly in and around Stockholm.

Once an icon of progressive West European social democracy, Sweden is today fast turning its back on the traditional model of nationalised health provision and funding[9].

In France, Germany, Italy and elsewhere in Europe[10] the story is similar. As the boundaries of public sector funding and capability are reached so people's dissatisfaction with state healthcare is growing ever more vocal. Just as

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[7] See: http://www.davidgratzer.com/codeblue.php Also see: David Gratzer, (1999) Code Blue: Reviving Canada's Health Care System, Montreal and Toronto, ECW Press.
[8] Ibid.
[9] Johnny Munkhammar (2005) European Dawn: After the Social Model, Timbro Publishers, Stockholm.

privatisation and liberalisation have been used to transform many state industries in these countries over the last two decades, so such policy ideas are being applied to the so-called human services of healthcare, education and welfare.

Across the world, traditional assumptions surrounding healthcare are being questioned as never before. As the Organisation for Economic Co-operation and Development (OECD) recently made clear:

> "OECD health systems are facing a number of major policy challenges. Rising demand due mainly to population ageing, rapid innovation and diffusion of medical technology [have led to concerns] about efficiency in provision."[11]

Questioning the state's role in healthcare

Following the supply side revolution of the 1980s, a small but growing number of academics, politicians and other opinion formers are citing government failure as the enemy of better healthcare not markets. Attacking government interventionism in healthcare the flaws they commonly note include:

- monopoly provision of health services
- lack of accountability
- politicisation of health care decision making
- barriers to innovation
- lack of regular and reliable information about health outcomes.

Today, many twentieth century assumptions concerning the failure of markets to effectively deliver healthcare are being challenged and a new consumer oriented orthodoxy espoused.

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[10] Ibid.
[11] July 2001, The OECD Health Project can be found on www.oecd.org

Libertarian writers such as David Friedman[12] and Brian Micklethwait[13] controversially argue that there is no such thing as market failure in healthcare, instead many of the problems popularly imputed upon so-called healthcare failure is invariably the result of various forms of government intervention.

In Britain, as in many other developed countries, the healthcare debate ultimately takes two popular forms. One opinion views state healthcare, in the British case the National Health Service, and the idea of healthcare being free at the point of delivery, as being a sacred non-negotiable principle. This perspective is accurately portrayed in the following terms:

> "That people should be left to die for the mere lack of a few thousand quid for some machine that will mimic one of their organs is an abomination. We are falling behind our continental rivals, who spend a far higher proportion of their GNP on medical care. Public opinion has again and again revealed itself eager for more health care spending, and content to pay more in taxation to finance such increases. The idea of turning the whole show over to those overpriced peacocks in the medical private sector is appalling, not to say a recipe for the American health method, which is that if you get sick, you are either bankrupted or you die."[14]

Popular opinion number two asserts that the National Health Service is simply another nationalised industry and that it has all the characteristic failures of such an institution. Here, this school of argumentation can be summarised as follows:

> "Price anything at zero (or thereabout), and the queue for it will stretch out infinitely. Give a succession of blank cheques to any organisation and the

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[12] David D. Friedman (1989) The Machinery of Freedom: A Guide to Radical Capitalism, Open Court Publishing, Chicago.
[13] Brian Micklethwait, (1991) How and How Not to Demonopolise Medicine, Political Notes. 56., Libertarian Alliance, London.

people running the thing will tend to abscond with or waste most of the money, even as they complain about the stinginess of the cheque signers. However, the British public being so incomprehensively wedded to the NHS, and so infuriatingly unimpressed by the medical private sector, they must not be told point blank and to their faces that the NHS ought to be closed down. No, one must be "realistic". One must instead speak of "reforming" the NHS, and of making it less wasteful and better managed."[15]

For classical liberals and libertarians in general the truth lies far beyond both of these positions.

For them the root of the problem is that British medicine, *all* British medicine be it formerly NHS or independent sector, is ultimately a government sponsored monopoly. This is because to be a doctor one must be accepted as such by the General Medical Council (GMC). Or to put it another way the government, on advice from doctors, chooses the doctors who choose and unchoose all the other doctors. Importantly:

"If you are not or are no longer a "doctor" (as the government, advised, by its preferred bunch of doctors, understands that word), then there are three things you may not do. These are, in ascending order of importance: sign death certificates, prescribe drugs, and (in general) take medical risks....In other words, medicine is a government sponsored monopoly. You can't practise medicine in any significant way if you can only prescribe insignificant drugs or cures, and only take insignificant risks. So far as I can judge it, things are approximately like this everywhere. In no country on earth is medicine un-interfered with by the local state."[16]

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[14] Brian Micklethwait, ibid., p.1.
[15] Ibid.
[16] Brian Micklethwait, ibid, p.2.

In Britain and elsewhere in Europe, the United States of America is often seen as having the most extreme possible example of a free market health system. Yet in reality, there is little - if any - widespread understanding of the existence of Medicaid or Medicare. Today, most British people would find it hard to believe that the US government has any major state healthcare programs – let alone historically spend a greater proportion of its national wealth on them than the British government does on the NHS[17].

Yet America does have large state healthcare programs, it does spend a substantial proportion of its national income on them and it is arguably even more restrictive when it comes to medical risks and safety than virtually anywhere else in the world. As one commentator recently observed:

> "There, under the influence of a deranged generation of lawyers whose aim seems to be to bring civilisation itself to a standstill, *nobody* is now allowed to take medical risks, *not even doctors.* If anything goes wrong with *any* medical procedure, then no matter how conscientiously the risks were explained to the patient and no matter how many forms he signed saying that yes he understood this and please could they get on with the operation, if things then go at all badly wrong, the patient – or if he dies his relatives – can then sue the doctor for double the doctor's life savings. To spell this out in plain English, what the Americans lawyers are engaged in doing is *making medicine illegal. All* medicine, even medicine practised by the one government favoured American trade union. Add this obsession with safety to the fact that the American Medical Association has the same armlock on American medicine as the GMC has here, and it is hardly to be wondered at if American medical services are cripplingly expensive, and are becoming more so."[18]

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[17] David Green (1985) Challenge to the NHS A Study of Competition in American Health Care and the Lessons for Britain, London, Institute of Economic Affairs.
[18] Brian Micklethwait, op.cit., p.2.

For classical libertarians the everyday debate about the ownership of hospitals and funding schemes is important but ultimately superficial. For them, the health policy debate should be more concerned with the medical monopoly and its consequences than the usual questions surrounding nationalised industries:

> "A free market would be something else entirely. In a free medical market, the very process of defining *who is and who is not a doctor would be negotiated entirely between the people offering themselves as doctors and the people deciding whether to submit themselves to these doctors as patients*...At the heart of the medical issue is the right of the individual to take whatever risks he wants to take and make deals on what basis, and the duty of any court, lawyers and politicians to respect rather than retrospectively overturn these details."[19]

For Micklethwait a real free market would mean that people would be able to take whatever drugs they wanted to and medical practitioners would be able to advertise their services. Overtime a new consumer driven market reliant upon reputation – not state regulation - would emerge.

> "Far from being obvious to me that a truly free medical market would be disastrous, I believe on the contrary that such arrangements would be of huge benefit to mankind, and that the sooner medicine is done this way the better.
>
> "Things would not, inevitably, be perfect. Some fools would make crass blunders, by ignoring manifestly superior medical services for the most frivolous of reasons, and by patronising the most notoriously incompetent. Some such fools would perish from their foolishness. Others would merely be unlucky. No law can prevent either stupidity or bad luck, although the

[19] Ibid.

world is now filled with the particular stupidity which consists of refusing to face this truth, and with the many luckless victims of this stupidity."[20]

He concludes:

"Given that for most people the avoidance of suicide rather than suicide is the objective, a truly free medical market would enable them, for the first time ever, to purchase steadily improving medical advice and medical help, and at a steadily diminishing price.

"One of the most pernicious restrictions on medicine imposed by the current medical regime is the restriction on advertising. In a free market rival medical procedures, rival medical "philosophies", rival views on the relative importance of confidentiality, hygiene, speed of treatment, riskiness of treatment, and so forth, would all battle it out in the market place. "Alternative" therapists would be allowed to prescribe potentially dangerous drugs, as only government favoured therapists may now. It would be up to the patients to pick therapists who seemed to know what they were doing and their look out if they chose badly. The already thriving medical periodical press would assist with voluminous comparative advice, praise and criticism.

"In such a free market, any number of different medical styles could be practiced, and patients would make their choices."[21]

Exploring health markets and the idea of failure

While libertarian writers hold controversial and radical views, a growing number of mainstream commentators are citing government regulation and interference

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[20] Ibid, p.3.
[21] Ibid.

in the so called health market for being against the public and professional interest. And it is to this area of inquiry that the rest of this study is primarily concerned.

Away from such highly charged notions as who is actually right in this debate, or even by what criteria such an assertion could be judged, this study is primarily interested in how healthcare opinion formers think about health economics and the causal links they make concerning the production of outcomes.

How for instance do healthcare opinion formers react to such notions as monopoly and choice, regulation and reputation and advertising restrictions and consumer information?

With this exploration in mind, the next chapter begins with an examination of the literature and history of market failure in health economics and other areas of mainstream economic and political science.

Chapter three then goes on to examine the history, growth and experience of British healthcare prior to the creation of the National Health Service in 1948.

Away from modern notions of market failure and government intervention, it introduces a much wider history of British healthcare. In beginning to test today's popular notions of market failure, a wide range of historic evidence and literature is reviewed.

Overall, the chapter argues that since Roman times, political elites in the British Isles have always sought to plan, control and regulate the provision of health services. Through the Roman military, then the church, the Royal Colleges, Parliament, the granting of professional legislative favour in the name of the 'public good', the state has systematically encroached on every area and facet of healthcare delivery.

Coming up to the modern world, the chapter argues that by the early 1940s the context in which full blown health nationalisation would occur had become compelling and seemingly inevitable.

Chapter four moves on to examine the record and history of the NHS. Analysing the service's intellectual roots and early aspirations, it explores its *de facto* record concerning capital investment, resource allocation, and comparative outcomes data – as well as a host of other socio-economic criteria. Data on the class breakdown of people who work in the service is presented, as is its record on the allocation of resources per illness episode by socio-economic group. Overall, the chapter presents a comparative overview of the performance of the service in relation to the aspirations of its founding fathers, the institutions that had pre-dated it and the ideas of its contemporary social democratic defenders.

Chapter five presents the methodology behind the study's empirical research into the opinions of a representative sample of British healthcare opinion formers. In doing so it explores how the respondent sample was sought, how the questions were framed, and how the data was collected and analysed.

Chapter six goes on to present the initial research findings. In presenting the data generated from the research it starts to clarify some of the conceptual boundaries surrounding commonly held notions of market economics amongst British healthcare opinion formers.

Chapter seven provides a comparative overview of the results and highlights the implications of the main findings. In exploring the attitudes and mindset of the people who oversee the current health policy debate it reveals a much greater acceptance for a role for markets and private healthcare than was previously the case.

Finally, chapter eight concludes the work by contextualising the overall research findings. In exploring the attitudes and beliefs of today's healthcare opinion formers it highlights the constraints and boundaries of current thinking.

CHAPTER II

THE RISE OF MARKET FAILURE AS AN IDEA IN MODERN HEALTH ECONOMICS

This chapter examines the literature and history of market failure as a concept in health economics and in other areas of mainstream economic and political thought. Away from questions of who is correct in the debate, or even by what criteria such an assertion could be judged, the chapter is primarily concerned with how modern health opinion formers have come to think about markets in health economics, and the causal links they make concerning both the production of health outcomes and consumer satisfaction.

Notions of Market Failure

Today, most people believe that there are circumstances in which the state should become involved in economic decision making – particularly in areas such as healthcare and education. Yet this is an area of debate and contention that has evolved over many decades. To fully understand how today's consensus has been reached and what constraints it places on the current healthcare debate in Britain, it is first important to explore the literature available and to delve further into the history of the idea of market failure.

While markets are often viewed as being excellent allocators of resources, by making sure that if there is a good or a service that a person values more highly than it costs to produce it then somebody will decide to produce it, there are nevertheless many problematic questions that seemingly arise.

Normally, when a market exchange takes place it is clear that both parties will be better off. That is, the net private benefit, which equals the private benefit minus the private cost, is greater than zero, so X is produced and consumed.

However, markets are arguably problematic when the net private benefit of a market transaction does not equal the net social benefit - that is when the social benefit (the sum of private benefits of all individuals in a society) does

not equal or exceed the social cost (the sum of private costs of all individuals in a society). It follows from this logic that when net private benefit does not equal net social benefit, individuals can make exchanges that are privately beneficial but socially costly.

Today, many economists argue that if the government can intervene and bring private costs and benefits more in line with true social costs and benefits, the exchanges that occur will, on a net basis, be more socially beneficial. For them, government intervention can be easily justified.

One rationale that economists often use for government intervention involves externalities and the problem that markets are said to have in coping with them. An externality occurs when, as Tyler Cowen has put it:

> "...one person's actions affect another person's well-being and the relevant costs and benefits are not reflected in market prices."[1]

Externalities therefore, cause net social benefit to diverge from net private benefit. However, it is important to recognise that in arguing that private net benefit sometimes differs from social net benefit it does not automatically justify government intervention. For as Cowen has himself pointed out:

> "The imperfections of market solutions to public goods problems must be weighed against the imperfections of government solutions. Governments rely on bureaucracy and have weak incentives to serve consumers. Therefore, they produce inefficiently."[2]

According to Edwin G. West[3], to understand the modern concern with externalities and the idea of market failure one has to go back to the writings of the early advocates of laissez faire in the eighteenth and nineteenth

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[1] Tyler Cowen, 'Public Goods and Externalities', The Library of Economics and Liberty, on-line at: http://www.econlib.org/library/Enc/PublicGoodsandExternalities.html
[2] Ibid.
[3] Edwin G. West, Classical Libertarian Compromises on State Education, The Freeman, October 1996, The Foundation for Economic Education, Irvington-on-Hudson, New York.

centuries and to first examine their treatment of education. For it was in this area that the early advocates of classical liberal ideas began to accept the need for government intervention in some instances and therefore, by implication, encourage the idea of 'market failure' as a notion in modern economics.

For West, early libertarians such as Tom Paine, Adam Smith and John Stuart Mill were inconsistent thinkers. And "their tendency to compromise seriously weakened the defences against the all-encompassing state"[4] – particularly later, in areas such as healthcare.

Early Libertarian Compromises on State Education

In his famous book *The Rights of Man*[5], first published in 1791-1792, Tom Paine argued that the quantity and duration of education being received by most children was insufficient and that the shortfall was not due to an inherent unwillingness on the part of parents to adequately educate their offspring, but simply due to poverty.

For Paine, poverty in turn was mainly caused by excessive taxes on the poor. General taxation and in particular the excise had systematically increased during the late eighteenth century. However, land taxes – paid predominantly by the aristocracy - had been decreasing.

At that time, just over half of all tax revenue serviced a substantial national debt. The remainder was spent on current government expenses that Paine believed to be extravagant and unnecessary. He insisted that the money taken in taxation from ordinary people and average families was more than enough to finance a basic education for their children.

After producing a radical agenda for reducing government expenditure, Paine outlined his thoughts on how to dispose of what he called the surplus.

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[4] Edwin G. West, op.cit., October 1996, p.652.
[5] Tom Paine, (1961) [1791] The Rights of Man, Everyman, London.

However, instead of proposing a simple reduction in taxes for the poor, as the overall direction and logic of his argument pointed, he instead advocated a *conditional* remission of taxes. The condition was that parents should send their children to school to learn reading, writing and arithmetic.

As such, Paine was essentially advocating a voucher scheme. But who did he suggest would monitor such a system? On this point, he had no qualms in recommending that this function should fall to a minister in each church parish:

> "The ministers of every parish...to certify jointly to an office, for that purpose, that this [educational] duty be performed."[6]

After speaking up for the liberty of the average man, Paine made it clear that he ultimately mistrusted him. As West argues:

> "The implication was that if simple tax reduction was resorted to, the people could not be depended on to spend enough of their increased disposable incomes on education. Yet Paine's initial argument was that it was heavy taxation that was the main obstacle to private purchase of education. He had no evidence that the reluctance was due to basic family preferences. And even if it was, there remained the issue of liberty. Did Paine's rights of man not extend to freedom to decide the type and amount of education for their children? Unfortunately, however, he failed to address this question.
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> "Paine's voucher scheme demanded schooling; yet this was not the only vehicle for education. Why then did he superimpose his own choice? And why should ministers of religion have the sole right to monitor the voucher program? Would they not increasingly modify the definition of education to become more and more in conformity with

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[6] Tom Paine, op.cit, p.248.

their particular religious creed? What constraints were there on the size of the special office that Paine wanted the ministers to report to?"[7]

Adam Smith's famous 1776 book *The Wealth of Nations*[8] argued that economic prosperity and growth will primarily occur when natural liberty is respected and leads to participation in the division of labour. However, in Book V, he argued that when specialisation reaches its fullest development the worker "becomes as stupid and ignorant as is possible for a human creature to become".[9]

Smith's forecast of the wholesale degeneration of labour was based on the argument that government would fail to take the necessary steps to prevent it. Therefore, the main role of government is to secure the education of the common people.

Like Paine, Smith mistrusts the capacity of ordinary people to educate their children. Once a market economy establishes its concomitant division of labour, "The minds of men are contracted and rendered incapable of elevation. Education is despised, or at least neglected..."[10]. Simultaneously observing that people of some rank and fortune have money to afford education, Smith declares: "It is otherwise with the common people. They have little time to spare for education. Their parents can scarce afford to maintain them even in infancy."[11]

Here, Smith falls into the same contradictory trap as Paine. As West asserts:

> "To maintain that poverty is the formidable obstacle tells us nothing about the real tastes of people for education. The only true test is to see what happens when poverty is removed. But in any case even if

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[7] Edwin G. West, op.cit., October 1996, p.653-654.
[8] Adam Smith, (1976) [1776] An Inquiry into the Nature and Causes of the Wealth of Nations, reprinted in two volumes, R. H. Campbell, A. S. Skinner, and W. B. Todd, eds, Clarendon Press, London.
[9] On this see Edwin G West, October 1996, op cit., p.654.
[10] Ibid.
[11] Adam Smith, (1976) op.cit., p.784

people would buy less education than Smith would like, his willingness to bring in government would appear to conflict with his famous principle of "natural liberty"."[12]

Smith is inconsistent in yet another sense too. His position that many parents were too poor to educate their children conflicted with his general economic argument that wages per capita had been rising for two centuries and that further progress to higher stages of the division of labour through the invisible hand was expected to bring greater monetary rewards for all ranks of society. If Smith expected real incomes to continue to rise surely leisure and education would become more affordable too?

Indeed, Smith's prediction of rising real incomes is clearly borne out by the evidence. The general conclusion of economic historians is that in Britain by 1850 real wages were about double those of 1801-1804.[13] Similarly, his view that a systematic rise in real incomes would lead to increases in leisure activity was unambiguously borne out by the fact that people's hours of work steadily declined.[14]

While the state's major educational intervention in England and Wales came in 1870 when the Forster Act introduced government schools for the first time, by 1869 most people were already literate.[15] Contrary to popular Dickensian mythology most children were already receiving schooling and most working class parents were paying private fees for it. It is therefore arguable that by the time the state intervened, the market was already well on its way to providing the levels of education that Smith and Paine had previously desired.

Commenting on Smith's inconsistency, West concludes:

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[12] Edwin G. West, October 1996, op cit., p.654.
[13] R. S. Neale, The Standard of Living 1780-1844: A Regional and Class Study, in Arthur J. Taylor, (1976) The Standard of Living in Britain in the Industrial Revolution, Methuen, London, p.173.
[14] Joseph S. Zeisel, The Workweek in American Industry 1850-1956, Monthly Labour Review, (1958) pp. 81, 58.
[15] Edwin G. West, (1970) Education and the State, Institute of Economic Affairs, Second Edition, London, p.xvii.

"The Scottish Act of 1696, which impressed Smith, laid down that a school should be erected in every parish and that teachers' salaries be met by a tax on local heritors and tenants. This schooling, however, was not made compulsory by law; and neither was it made free. The parental fees made up a big part of the teachers' salaries and were paid by every social class. Indeed, the Scots did not have "free" and compulsory schooling until about the same time the English did in the 1880s. The more Smith championed the Scots parochial school system, therefore, the more implicit credit he was paying to working parents. Their action in voluntarily paying fees to purchase education at the parish schools was obviously a tribute to them in Smith's own time despite his contrary statement...that education would be "despised" after the division of labour was established.

"More interesting still, it was the fee-paying private schools that were bearing the main burden of Scottish education in terms of the number of scholars. For every one Scottish parochial school pupil in 1818 there were two non-parochial school pupils. And the latter outnumbered the former by much more than two to one in the growing industrial areas such as Greenock, Paisley, and Glasgow – the very areas where Smith argued there was greater need for schooling."[16]

Like Tom Paine and Adam Smith, J. S. Mill has the reputation for being a serious advocate of freedom of the individual. In his celebrated 1859 essay *On Liberty*[17], Mill asserted that:

> "...the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others."[18]

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[16] Edwin G. West, October 1996, op cit., p.656. See also, Select Committee on Education of the Poor, Parliamentary Papers, 1818, III. There is also an account of this paper in Edinburgh Review XCI, 1827, pp. 107-132.
[17] J. S. Mill, (1962) [1859] On Liberty, Fontana, London.
[18] Ibid., p.135.

When it comes to education and schooling, Mill scores many points with modern libertarians as a result of his famous remark that:

> "A general state education is a mere contrivance for moulding people to be exactly like one another...in proportion as it is efficient and successful, it establishes a despotism over the mind, leading by natural tendency to one over the body."[19]

However, this statement should not be read as endorsing a free market in education. For on this idea, Mill was opposed. Instead, he believed that "the uncultivated cannot be competent judges of cultivation."[20] In other words, market failure occurs because:

> "...persons requiring improvement, having an imperfect or altogether erroneous conception of what they want, the supply called forth by the demand will be anything but what is essentially required."[21]

Failing to acknowledge the empirical evidence around him, Mill seems to have made the same critical error that Smith did before him. He protested that:

> "...even in quantity it is [in 1848] and is likely to remain, altogether insufficient, while in quality, though with some slight tendency to improvement, it is never good except by some rare accident, and generally so bad as to be little more than nominal."[22]

From this statement it is clear that Mill could not have read any of the national reports on education, not least because the first full census commenting on schooling did not appear until 1851 – three years after he had written the previous quote. Instead, it seems likely that he relied heavily on the highly

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[19] Ibid., p.239.
[20] J. S. Mill, (1969) Principles of Political Economy, Augustus Kelly, New York, p.953.
[21] Ibid.
[22] Ibid., p.956.

questionable information and data provided by his circle of radical and utilitarian friends, such as John Kay of the Manchester Statistical Society.[23]

On the highly subjective matter of quality, Mill even failed to explore one of the major outputs of education – literacy. Yet we now know from the leading historian of this subject, R. K. Webb, that by the late 1830s between two-thirds and three quarters of the working classes were already literate.[24] So despite Mill's general dislike of governmental provision of education he, like Paine and Smith before, was willing to compromise.

The first part of the compromise was his reconciliation to the idea of some form of limited state education:

> "Though a government, therefore, may, and in many cases ought to, establish schools and colleges, it must neither compel nor bribe any person to come to them."[25]

Again, a state school should exist:

> "...if it exists at all, as one among many competing experiments, carried on for the purpose of example and stimulus, to keep the others up to a certain standard of excellence."[26]

Without any real and substantive evidence, Mill made the presumption that state schools would always be superior pacesetters.

The second of Mill's major compromises was his insistence that education should be made compulsory. While he acknowledged that compulsory education should not be equated with compulsory state schooling, he sought to underpin the idea with the public enforcement of examinations:

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[23] Edwin G. West, 'The Benthamites as Educational Engineers', History of Political Economy, 1992, 24:3.
[24] Edwin G. West, October 1996, op cit., p.656.
[25] Mill, op cit., 1962, p.240.
[26] Ibid.

> "Once in every year the examination should be renewed, with a gradually extending range of subjects, so as to make the universal acquisition and what is more, retention, of a certain minimum general knowledge virtually compulsory."[27]

Ultimately Mill endorsed Bentham's utilitarian system of examinations as the price to be paid for the right to a vote. Yet, his ideas did not in any way suggest a fundamental removal of state power in the area of education. Instead, he sought only to restrict its authority to the power of those state officials who would now oversee an examination system. For him, providing these examinations were confined to the "instrumental parts of knowledge" and the realm of objective fact then a minimum state was acceptable.

However, Mill never entered into a debate concerned with what would constitute a certain minimum of general knowledge? He never addressed the fundamental question of who was to determine the subjects to be taught? How would one choose between, say, political economy or geography? He never pronounced on whether powers of censorship could be easily exercised? Or what should happen if certain individuals had aversions to certain subjects? Mill himself for instance strongly objected to the teaching of theology and profoundly believed that national education should be a strictly secular affair.

Overall, his desire to judge ordinary people led him to make exactly the same error as Tom Paine and Adam Smith had. Yet, while Paine and Smith had argued that people were simply too poor to purchase education, Mill's version of this non-sequitur went as follows:

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[27] For more on this see Edwin G. West, October 1996, op cit., p.656

> "In England...elementary instruction cannot be paid for, at its full cost, from the common wages of unskilled labour, and would not if it could".[28]

Yet, how did he know this to be true? In reality, as West concludes:

> "We have here, it seems, not so much the libertarian as the intellectual paternalist with noble intentions. Certainly his treatment of other people's opinions on this subject seemed to contradict the spirit of Mill's On Liberty as it is popularly conceived."[29]

When it came to education, Tom Paine, Adam Smith and J. S. Mill were not radical libertarians. Instead, they are perhaps better categorised as being free market conservatives. For ultimately, their primary objective was the liberation of the masses into a world of culture – their conception of what constituted culture.

In articulating this worldview, they all made significant compromises that legitimised the intervention of the state. While their support for the free market led them to favour private tuition fees, they failed to foresee the scale and consequences of the government bureaucracy they were promoting.

Interestingly, it was left to another more radical libertarian, William Goodwin to defend the unfettered market. A philosopher by background, he prophetically warned in 1796:

> "Before we put so powerful a machine under the direction of so unambiguous an agent, it behoves us to consider well what it is that we do. Government will not fail to employ it to strengthen its hands and perpetuate its institutions."[30]

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[28] Mill, op cit., 1962, p.959.
[29] Edwin G. West, October 1996, op cit., p.656.
[30] William Goodwin, (1796) Enquiry Concerning Political Justice and its Influence on Morals and Happiness, London, p.297.

Similarly, the French economist Frederic Bastiat, far from emphasising the social benefits of education as a justification for public expenditure, instead focused on the social costs of public expenditure as a justification for keeping government out of education – as well as most other endeavours including health care. In his 1850 work *Economic Harmonies*[31] he wrote of the moral and intellectual decay that results from the state's attempt to satisfy a human want through services rendered publicly rather than privately:

> "When the satisfaction of a want becomes the object of a public service, it is in large part removed from the sphere of individual freedom and responsibility. The individual...ceases to exercise free control over the satisfaction of his own wants, and, no longer having any responsibility for satisfying them, he naturally ceases to concern himself with doing so. Foresight becomes as useless to him as experience. He becomes less his own master; he has lost, to some extent, his free will; he has less initiative for self-improvement; he is less of a man. Not only does he no longer judge for himself in a given case, but he loses the habit of judging for himself. This moral torpor which takes possession of him, likewise takes possession of his fellow citizens, and we have seen entire nations fall in this way into disastrous inertia."[32]

Although Bastiat's perspective was not simply about the social costs attendant on education *per se*, it was a broad rebuttal to an ever increasing number of commentators who, following Paine, Smith and Mill, supported government intervention as a means of generating social benefits – not least on the basis of cultural and even national character.

In Alfred Marshall's classic textbook first published in 1890, *Principles of Economics,*[33] the social costs and benefits of involving the state's provision and funding of education was discussed more in terms of political and moral

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[31] Frederic Bastiat (1850) Economic Harmonies, reprinted 1996, Irvington-on-Hudson, The Foundation for Economic Education.
[32] See: Ibid., Chaper 17, 'Public and Private Services'.
[33] Alfred Marshall, (1920) Principles of Economics, Eigth Edition London, Macmillan & Co.

philosophy than economics. In Book IV, Chapter VI, he discussed the merits of state intervention in industrial training and in paragraph seventeen asserted:

> "There is no extravagance more prejudicial to the growth of national wealth than that wasteful negligence which allows genius that happens to be born of lowly parentage to expend itself in lowly work. No change would conduce so much to a rapid increase of material wealth as an improvement in our schools."[34]

Expanding on this theme he continued:

> "We may then conclude that the wisdom of expending public and private funds on education is not to be measured by its direct fruits alone. It will be profitable as a mere investment, to give the masses of the people much greater opportunities than they can generally avail themselves of. For by this means many, who would have died unknown, are enabled to get the start needed for bringing out their latent abilities. And the economic value of one great industrial genius is sufficient to cover the expenses of the education of a whole town."[35]

Marshall's support for the state funding of schools came from his straightforward belief that general schooling would allow more people of exceptional talent and vigour to become productive and that the additional innovation and productivity they would create would more than pay for the public expense of education.

A similar argument was presented by Charles F. Bastable concerning state intervention in the technical education for trades. In Book I, Chapter V of his 1892 book, *Public Finance*[36], he made an explicit appeal to the idea of net

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[34] Ibid.
[35] Ibid.
[36] Charles F. Bastable (1892) Public Finance, reprinted 1917, 3rd edition, London, Macmillan & Co Ltd.

social and private benefit discrepancies concerning technical education. He asserted that:

> "Expenditure on such an object is productive even in a financial point of view, and it may further be argued that individual or family interest will not suffice to accomplish the end desired."[37]

While he did go on to note the potential drawbacks of state intervention in technical education, he nevertheless repeated the argument that "public outlay may be of advantage in promoting industrial training".[38]

Taking all of these writers together, it is clear that during the late eighteenth century and through the nineteenth century a consensus was reached whereby state education was seen to impart social benefits not captured by private calculations. Although there was a variety of opinions on exactly what these benefits were, the direction and course was clear.

While Goodwin and Bastiat in their own ways confronted these views head-on, history demonstrates they were not sufficiently powerful in their persuasion of wider opinion. Their view, that state education would in turn generate its own highly damaging social costs, failed to capture the popular and moral imagination. Their belief that government was not a cure in education but would worsen the situation failed to capture hearts and minds. It fell on deaf ears.

For Edwin G. West what happened in the education debate was to have serious ramifications in other areas – particularly healthcare. Once esteemed and early classical liberals such as Paine, Smith and Mill could be cited for acknowledging a justifiable role for the state in education, it was perhaps only a matter of time before subsequent generations of more statist intellectuals would actively exploit and build upon this – theoretically inconsistent - position.

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[37] Ibid.
[38] Ibid.

Indeed, the writings of Marshall and Bastable attest to a new and fast emerging consensus. It was not long before the new forms of state intervention they so eloquently described became a reality that was duplicated and spread across other economic sectors.

By the late nineteenth century, intellectuals and opinion formers in the most advanced nations of the world were becoming increasingly attracted to the ideas of a new technocratic modernity based on the centralising principles of municipal and public sector benevolence. In education, law enforcement and healthcare the seeds of state intervention had been firmly sown. They were being ploughed and nurtured in the mindset of market failure.

Private Supply of Public Goods

Today, it is popularly believed the there are many goods essential to the functioning of society which can be produced only by the state. The public good thesis in Britain may be summarised in the following historic terms:

> "The unrestricted operation of market forces in nineteenth century Britain produced grave consequences, especially a lack of major public goods as public order, sanitation and education. This shortcoming was remedied only by a massive expansion of the state, without which capitalist society would have broken down. The market was unable to solve these difficulties."[39]

Today, to question this version of history seems strange and almost inappropriate. However, while there was certainly a massive expansion of the state in the nineteenth century – and, as such, the idea of a Victorian age of *laissez-faire* is at least in part a myth – the key question is was this expansion necessary. As the historian Stephen Davies has commented:

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[39] This line was the theme of a television series, based upon the book, Victorian Values. The series and the central thesis were summarised in a powerful article by Peter Kellner later published in The Independent. Peter Kellner, 'Thatcher's Flawed View of the Past', The Independent, 13 April 1987; J. Walvin, (1987) Victorian Values, London, Andre Deutsch.

> "Surely the Blue Books, official reports and the works of social investigators reveal a horrendous state of affairs in the early nineteenth century, with large towns and cities lacking such elementary facilities as water, lighting, and an effective police force to protect the public from rising crime? Weren't the inhabitants deprived of education and other elements of culture? Certainly, the condition of many larger towns and their inhabitants *was* often deplorable. These deficiencies had two main causes: a sharp rise in population, coupled with large-scale urbanisation; and an utterly inadequate system of local government, riddled with corruption and jobbery. "[40]

One set of proposals – and ultimately those that were successful – was put forward by reformers such as Edwin Chadwick, who forcefully argued for a reconstruction of the State.[41] But there was a different view put forward by more libertarian inclined thinkers to remove the restrictions of the established and largely corrupt system. The view here was to allow the market to produce the solutions necessary.

Indeed, research which moves beyond the official publications of the day, reveals that this was actually happening. And a brief examination of two separate activities where private provision of public goods was far advanced by the 1830s serves to demonstrate this reality.

For Davies, policing and law enforcement, and the supply of water and sanitation, both illustrate the tenuous and fragile record upon which modern notions of market failure have become so firmly established in the popular mind.

The years between 1750 and 1850 saw the rapid development of a multitude of private agencies of law enforcement. The services on offer ranged from the

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[40] Stephen Davies, (1987) The Private Supply of 'Public Goods' in Nineteenth Century Britain, Historical Notes No.3., Libertarian Alliance, London, p.1.
[41] S. E. Finer, (1952) The Life and Times of Sir Edwin Chadwick, Methuen, London.

systematic use of newspaper advertising to professional detectives and thief-catchers.

The most significant were the private associations for the prosecution of felons. These were voluntary associations of citizens that were initially set up to defray the sizeable costs of mounting criminal prosecutions and that over time grew to resemble private police forces. Overtime they acquired, by popular market demand, a wide range of functions including crime-prevention and insurance.

Association members paid for these services in proportion to their ability to pay. The income was then used to pay for compensation for loss through theft or criminal damage; to recover stolen goods wherever possible; to cover the cost of criminal prosecutions - and for the compiling of information against known delinquents. Moreover, the monies were used to finance permanent community foot-patrols or watchers.

Between 1744 and 1856 at least 450 such associations were set up in Britain.[42] By the 1830s the largest and most successful of these organisations – agencies such as the Barnet Association - had effectively become private police forces in their own right. The evidence suggests that they were highly successful and provided a service that was reasonably priced, efficient and popular. The membership spanned the social classes and was by no means simply confined to the well healed.

Similarly, at the beginning of the nineteenth century the supply of water and sanitation was mainly in the hands of the chartered private water companies. Although these organisations did not receive a favourable press following the

[42] A. Schubert, 'Private Initiative in Law Enforcement: Associations for the Prosecution of Felons, 1774-1856', in V. Bailey (ed) (1981) Policing and Punishment in Nineteenth Century Britain, Croom Helm, London.

1842 Sanitation Report,[43] the picture was arguably rather more complex than a simple reading of this influential document suggests.

In many areas, such as Ashton-under-Lyne, private water companies worked effectively and provided high quality water at a constant supply and at high pressure.[44] While in London there were problems with the supply of water and sanitation, as most contemporary commentators acknowledged, the central problem was the lack of competition and the chaotic state of local government. In the metropolis there were 300 separate bodies operating under 250 local Acts.[45]

Under examination, similar points can be made in other service areas at this time. In law, there was a vigorous development of private arbitration. And in fire services, major insurance companies such as Sun Alliance led the way with private market solutions.[46] Overall, the nineteenth century saw an explosive growth in the private supply of public goods, with some examples surviving to this day - such as the Royal Lifeboat Institution founded in 1824.[47]

However, given this historical evidence the question again presents itself – why was the statist solution adopted? This is a complex area but some suggestions can be made. Dr. Davies agues:

> "The problems were so acute in many cases that drastic action did seem necessary. The laissez-faire solution could be blocked by the vested interests of the old order and was not supported by a sufficiently powerful interest group. By contrast the state reformers had a coherent ideology in Benthamism and were able to work with the vested

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[43] For an analysis on this report see: M. W. Flynn (ed) (1965) Report on the Sanitary Condition of the Labouring Population of Great Britain by Edwin Chadwick, 1842, Edinburgh University Press, Edinburgh.

[44] P. H. Holland, (1846) Report on the Ashton under Lyne Water Works, Towns Improvement Company, London.

[45] Stephen Davies, (1987) op.cit., p.2.

[46] H.W. Arthurs, (1985) Without the Law: Administrative Justice and Legal Pluralism in Nineteeth-Century England, University of Toronto Press, Toronto.

[47] Nigel Meek (1999) The Plausibility of Large-Scale, High-Tech, Voluntarily-Funded Emergency Organisations: The Example of the Royal National Lifeboat Institution, Economic Notes No.86, Libertarian Alliance, London.

> interests, even if some of their more radical proposals were thwarted. The central figure in this movement was Edwin Chadwick, whose career is classic proof of the importance of outstanding individuals in history. Yet the main reason for the 'triumph of the state' was the fear of the mid-Victorian elite that society was facing the prospect of moral disintegration. They feared that economic development was dissolving the social bonds and producing an atomised 'state of nature'.[48]

On the question of the development of state education and the central importance of 'morality', he comments:

> "The primary objection to non-state education was its lack of moral instruction, while the prosecution associations were seen as inadequate because they concerned themselves only with such matters as crimes against property and person while ignoring 'moral' offences, such as prostitution and drunkenness. Even the debate over sanitation was thought to be as much about morals as about drains".[49]

Davies is critical of the fact that most historians have failed to adequately question their favoured sources in this area. He believes that highly impressionistic literary accounts are accepted as being the whole truth and that the accounts written by middle-class, often evangelical, observers are taken at face value with little attempt to identify the assumptions which informed them - or to test them against other evidence.

To him the most serious offence is the often unthinking respect given to official reports. For it has now been clearly shown that many of these publications, including the 1834 Poor Law, 1839 Constabulary and 1842 Sanitation Reports, are highly tendentious propagandistic works with evidence doctored and manipulated and "hearsay evidence or urban folk-myths presented as fact."[50] As Davies comments:

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[48] Stephen Davies, (1987) op.cit., p.2.
[49] Ibid.
[50] Ibid.

> "Thus the majority of respondents to the 1839 Constabulary Report said that they were satisfied with the existing state of affairs and saw no requirement for a state police force, and yet when Chadwick drew up the Report most of this evidence was simply omitted."[51]

Chadwick drew up all the Reports mentioned above. And behind this absence of criticism was his 'whiggish' view of history which saw the growth of the modern state as an inevitable and core part of 'progress'. For Davies therefore:

> "The historical evidence does not support arguments for the necessity of the state as a provider and regulator. Instead, it lends a support to the thesis that the market is capable of producing private solutions to the problem of 'public goods'."[52]

When asking what view can be reached from this re-examination of history, he concluded:

> "Mainly that the necessity of a large state for commercial society is not only unproven but even doubtful. It seems apparent that many of the 'core' functions of the state can be provided in quite a different way through the market. History can offer ideas as to how the state today may be replaced and even as to what a truly commercial society might be like."[53]

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[51] Mark Blaug, 'The Poor Law Report Re-examined', in The Journal of Economic History, 1964. For more on the 1839 Constabulary Report see: L, Radzinowicz, (1968) A History of English Criminal Law, Vol.IV, Stevens, London, pp.259-60. For more on the 1842 Sanitation Report see: G. Kearns, Private Property and Public Health Reform in England, 1830-1870, unpublished paper, Department of Geography, University of Liverpool.

[52] Stephen Davies, (1987) op.cit., p.2.

[53] Ibid.

Market Failure, Public Goods and Health Economics

By the end of the nineteenth century and for the first half of the twentieth, the command economy model was ascendant.

Whether further encouraged in Britain by the translation of Karl Marx's work into English in 1890, or by the rise of an essentially middle class Fabian elite that actively embraced parliamentary socialism[54]. The dominant ideas of most of the early twentieth century centred around the ideas of state planning, public sector benevolence and notions of equity.

At a time when the socially democratic economics of Keynes was arguing that politicians should run society through the principles of 'management by an intelligent elite', even many Conservatives found it attractive to argue for a so-called 'ordered middle way' between orthodox socialism and laissez-faire liberalism[55]. It was in this world of pre-Popparian thought that Harold Macmillan wrote:

> "The next step forward, therefore, in our social thinking is to move on from 'piece-meal planning' to national planning – from the consideration of each industry or service separately to a consideration of them all collectively."[56]

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[54] Hal Draper, 'The Two Souls of Socialism', New Politics Vol 5, No.1, Winter 1966.

[55] It is curious how the existence of an alliance of statist Toryism and Socialism has fallen out of any popular consciousness. One of the few studies can be found in Semmel, B., (1960) Imperialism and State Reform: English Social-Imperial Thought, 1895-1914, Harvard University Press, Cambridge M.A. There is a growing literature on eugenics, 'right wing' (that is, anti-capitalist and anti-liberal) social Darwinism and paternalism. See: Searle, G. R, (1971) The Quest for National Efficiency, Oxford Universisty Press, Oxford and (1986) Social Hygiene in Twentieth Century Britain, Croom Helm, London. Soloway, R. A., (1990) Demography and Degeneration: Eugenics and the Declining Birthrate in Twentieth Century Britain, University of North Carolina Press, Chapel Hill. Some socialist scholars are also beginning to reconsider the origins and nature of the rise of the welfare state in light of such evidence. See: Skocpol, T., (1992) Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States, Belknap Press/Harvard University Press, Cambridge M.A. Jamieson, L., and Corr, H., (eds) (1990) State, Private Life and Political Change, Macmillan, London. Dwork, D., (1987) War is Good For Babies and Other Young Children, Tavistock Publications, London. Under analysis, the origins of the welfare state looks less like the pure juice of human kindness and altruism, a liberation of the masses, and increasingly more like authoritarian social engineering for the sake of national strength, war or racial hygiene.

[56] Macmillan, H., (1938) The Middle Way, Macmillan & Co, London, p.176.

Given that Conservatism rested during this period upon such holistic notions as the subsumation of the individual to the politics of community, nation and empire, it is perhaps understandable that in the 1930s many leading Conservatives accepted the fashionable case for greater social planning and state intervention. Now convinced by the arguments concerning market failure, Macmillan for instance asserted:

> "Expert criticism has revealed the deficiencies of partial or piecemeal planning, and has made it clear that we must carry the idea of planning further, and evolve such a national scheme. We must take account of all the problems, and of all the repercussions of partial schemes with limited objectives. If we do not widen its scope, the whole idea of planning will be discredited.
>
> "...The weakness of partial planning seems to me to arise from the incomplete and limited application of the principles of planning. The lesson of these errors, which I regard as errors of limitation, is not that we should retreat. On the contrary, we must advance, more rapidly and still further, upon the road of conscious regulation."[57]

Around the same time, another Conservative commentator, Reginald Northam, similarly argued in favour of more state planning and interventionism. In his 1939 book, *Conservatism The Only Way*, he argued in the following terms:

> "...a prime consideration of the State must ever be to attempt to secure such conditions as will as produce the greatest employment, for it is in that way the national wealth can be most effectively produced and distributed.
>
> "...The emphasis must be on man, on human values and not on material values. Economic forces which would have an anti-social effect must be checked by the authority of the State. National wealth

[57] Ibid., pp. 10-11.

can be measured in terms of £ s. d. It can also be measured in terms of human happiness."[58]

Northam articulated a Conservative perspective typical of his generation. State interventionism and the individual's duty to the wider community were all combined into a powerful cocktail built on the assumptions of market failure:

> "Action by the State in determining the flow of trade which we have seen in these post-war years, is more typical of our traditional outlook than the laissez-faire attitude of previous generations.
>
> "...The responsibility of the individual is to realise his duty to the community into which he has been born, in order, not only that he may become the biggest he can become in that community, but also that the rights which our forefathers gained for us through service may be retained for us and may be passed on to those who come after".[59]

In mid and late twentieth century Britain such notions were the consensual backbone of mainstream political culture. And where markets were not perceived as achieving socially desirable outcomes, economists invoked the now popular notions of market failure.

Indeed, health economics – particularly as it emerged in Britain in the 1950s and beyond - has consistently emphasised the unique nature of health care; drawing on the view that market failure is somehow inherent and unavoidable. The conclusion reached is that in this particular area of welfare unfettered markets are wholly and inevitably inappropriate.

To social democratic and collectivist writers on health and welfare such as Tawney, Titmuss and Laksi,[60] social justice and equality are the key activating

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[58] Northam, R., (1939) Conservatism The Only Way, The Right Book Club, London, 105.
[59] Ibid., pp. 111, 115.

[60] Tawney R. H. (1912) The Agrarian Problem in the Sixteenth Century, London: Longman, Green and Co; (1921) The Acquisitive Society (1961 edn.), London: Fontana; (1926) Religion and the Rise of Capitalism (1938 edn.), West Drayton: Pelican Books; (1931) Equality (1964 edn.), London: Unwin Books; (1935) 'Christianity and the social revolution', New Statesman and Nation,

themes. They regard resources as being available for collective use and consequently favour government intervention. They criticise the pursuance of personal advantage rather than the general good - believing that the latter does not bring about the former. The market is criticised for being undemocratic, inasmuch as these thinkers believe it encourages decisions to be taken by a small power elite, and other people to suffer at the hands of arbitrary distributional forces. The market is also said to be unjust because it distributes rewards which are unrelated to individual need or merit, and because the costs of economic change are also distributed arbitrarily.

Under the influence of the social democratic paradigm and its value judgements, a set of standard assumptions have come to inform most modern health economics and from which a critique of the free market is derived. For example, in the standard text book *The Economics of the Welfare State*[61] the author, Nicholas Barr asserts:

> "Private markets allocate efficiently only if the standard assumptions hold – that is, perfect information, perfect competition, and no market failures such as external effects. The underlying question is why health care is 'different' from equally vital commodities like food."[62]

Following this highly value laden introduction Barr immediately goes on to further highlight his prejudice. Accepting the modern – highly regulated and corporatist – health market as being in some way analogous to a real free market process, he writes:

November; (1953) The Attack and Other Papers, London: George Allen and Unwin; (1966) The Radical Tradition. Twelve essays on politics, education and literature (ed. Rita Hinden), Harmondsworth: Penguin Books. Richard Titmuss, 'The Irresponsible Society', Fabian Tract 232, April 1960; (1962) Income, Distribution and Change, London; (1971) The Gift Relationship, London; (1974) Social Policy: An Introduction, London. Harold Laski (1933) Democracy in Crisis, Chapel Hill, The University of North Carolina Press; (1944) Faith, Reason, and Civilisation, Viking Press, London; (1948) Liberty in the Modern State, London, Allen & Unwin.

[61] Nicholas Barr, (1998) The Economics of the Welfare State, Third Edition, Oxford, Oxford University Press.
[62] Ibid., p 282.

> "Does medical care conform with standard assumptions? First, are individuals perfectly informed about the nature of the product (in analytical terms, is their indifference map well defined)? The answer, clearly, is no."[63]

Equating contemporary health care practices with a real market, he continues:

> "In addition, individuals are often ignorant about which types of treatment are available, and about the outcome of different treatments, which is often problematic. Furthermore, what little the patient knows is generally learnt from the provider of medical services; and many types of treatment (e.g. setting a broken leg) are not repeated so that much of what a patient learns is of little future use."[64]

Barr is typical of many academic commentators. On matters of consumer choice and information, he simply operates within the given – statist - institutional boundaries and therefore confidently asserts that with:

"Medical care:

- Much (though not all) the information is technically complex, so that a person would not necessarily understand the information even were it available.
- Mistaken choice is costlier and less reversible than with most other commodities.
- An individual generally does not have time to shop around if his condition is acute (contrast the situation with a car repair, which can be left until the car owner has enough information and can afford the repair).
- Consumers frequently lack the information to weigh one doctor's advice against another's.

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[63] Ibid.
[64] Ibid.

- Health and health care have strongly emotive connotations – for example, ignorance may in part be a consequence of fear, superstition, etc."[65]

Barr acknowledges that in some areas, such as hi-fis and used cars, consumers can buy information from consumer magazines or have it provided by trade associations, but interestingly he forgets to mention advertising. Without justifying his argument, he goes on to state – as if an *a priori* truth – that:

> "...health care is inherently a technical subject, so that there is a limit to what consumers could understand without themselves becoming doctors. The problem is exacerbated by the existence of groups who would not be able to make use of information even if they had it, such as victims of road accidents."[66]

There is no questioning here of whether health care really is more technically difficult or more challenging for consumers to understand than any of the other products mentioned – namely, motor cars and hi-fi systems.[67] There is no reference to the Libertarian argument that in a market consumers do not have to have perfect information or anything approaching it. Instead, they should have access to the commercial free speech, advertising and the reputations that emerge from brands over time.

When it comes to health economics as a discipline there is usually little if any reference to the role of brands or market driven reputation. Instead, there appears to be an implicit respect for the given boundaries of government intervention and statutory regulation.

For instance, turning to prices, Barr continues:

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[65] Ibid., p. 283.
[66] Ibid.
[67] Ibid.

> "Here, again, it can be argued that most consumers are ignorant of what a particular form of treatment 'should' cost; and, because a great deal of medical care is not repeated, information often has no future use. Nor would it help if consumers were well informed about prices. Rational choice requires simultaneous knowledge both of prices and of the nature of the product (i.e. of both budget constraint and indifference map); knowledge of prices without adequate information about different types of treatment will not ensure efficiency."[68]

Tellingly, Barr immediately goes on to assert that:

> "...if the only problem were inadequate information about prices, the appropriate intervention would be regulation, either in the form of a published price list or through price controls. But where information about the nature of the product is imperfect, ignorance about prices adds further weight to the argument for more substantial state involvement".[69]

The whole debate is couched in favour of state interventionism and state control. From the straw man of so called 'perfect information', the artificial edifice of imperfect prices is quickly established.

Again, working within given boundaries, health economists are quick to assert that "...the market solution is insurance".[70] And that:

> "The real issue, therefore, is whether the private market can supply medical insurance efficiently."[71]

Locked again into a world of similar *a priori* assumptions, health economists popularly assert that when we are considering health insurance markets there are five technical conditions to adhere to:

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[68] Ibid., p. 284.
[69] Ibid.
[70] Ibid., p. 285
[71] Ibid.

> "...the probability of needing treatment...must be independent across individuals, and less than one; it must be known or estimable; and there must be no substantial problem of adverse selection or moral hazard (the last three conditions adding up to perfect information on the part of the insurance company)."[72]

Not only are current models of insurance viewed as being indicative of a real free market in health care - a notion which is itself highly questionable for many libertarians - but issues such as adverse selection and moral hazard are typically discussed only in terms of market failure – not state sector (or political) failure.

The idea that, in a democracy, state health and welfare systems normally adversely favour – and thereby disproportionately benefit – articulate middle class recipients over poorer clients is usually excluded from text books. Similarly, the argument that state health and welfare systems can themselves encourage problems of moral hazard is normally marginalised or excluded from most mainstream literature.

When these things are occasionally referred to, interventionist – not market based – ideas, are then usually invoked as the logical next step. Hence, the following statement concerning market failures in health care:

> "Thus the lower-income individuals may have less information relevant to choices about health; in addition, they may be less able to make use of any information they acquire. In such cases intervention in the following forms may improve equity as well as efficiency.
>
> Regulation would be concerned with the professional qualification of doctors and nurses, with drugs, and with medical facilities in both public and private sectors.

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[72] Ibid., p.286.

> Where imperfect information causes under-consumption, a subsidy might be applied either to prices (e.g. free medical prescriptions) or to incomes.
>
> ...Where problems of inadequate information and inequality of power are serious, efficiency and equity may jointly be maximised by public allocation and/or production. In broad terms this depends on two factors: whether the private or public sectors is more efficient at producing health care; and whether monitoring of standards is more effective in one sector or the other."[73]

What starts out purporting to be about economics and an analysis of health care, soon degenerates into a stream of subjective and highly politicised assumptions concerning the constructed notion of market failure and the idea of state supported equity.

Criticising much mainstream economics Professor John Burton has argued in his paper, '*Economics: Still Dismal After All These Years*',[74] that the bias against genuine market processes generally occurs because students of economics are invariably taught to look at economic questions as a set of relatively simple and mathematically tractable equations. For him, the implicit assumption is that economic systems are one with a low order of complexity and therefore equitable with a mathematical system. He complains that:

> "Repeated exposure to this assumption in a variety of guises (the Keynes and monetarist macro models, Marshallian and Walrasian models of markets, etc.), has the unfortunate consequence of ingraining a habit of thought in the student. He starts to believe that real world economic processes are non-complex systems, and that they are just as manipulable as the equation systems that he is taught to handle mathematically."[75]

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[73] Ibid., p.290.
[74] John Burton, (1989) Economics: Still Dismal After All These Years, Economic Notes No.17, London, Libertarian Alliance.
[75] Ibid.

However, in recent decades a fightback against interventionist economics has gathered pace. Going beyond the tentative views of the early classical Libertarians mentioned above (Tom Paine, Adam Smith and John Stuart Mill), a new generation of thinker has emerged which challenges much of what has gone before. And it is to these writers and their ideas on healthcare that we now turn.

Libertarian Riposte

In 1920, Ludwig von Mises published his essay - *'Die Wirtschaftrechnung im Sozialistischen Gemeinwesen'* – Economic Calculation in the Socialist Commonwealth[76]. This paper - and Mises's subsequent works - ignited a fascinating debate in political economy that raged throughout the inter-war years. A devastating critique of Marxism,[77] and other fashionable advocates of command and control economics, Mises argued that in order for one to make sensible decisions regarding the allocation of factors of production, it is necessary to refer to the prices of these factors. If such prices were to be endowed with any degree of 'economic' rationale, then Mises considered it vital that they be established spontaneously in an 'anarchic' market.

Mises argued that abolition of markets for factors[78] would result in the inevitable breakdown of economic sectors and industry:

> "Under socialism all the means of production are the property of the community. It is the community alone which can dispose of them and which determines their use in production."[79]

Remove a market for factor inputs, no production good would "ever become the object of exchange",[80] hence, it would:

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[76] Ludwig von Mises (1935 [1920]), 'Economic Calculation in the Socialist Commonwealth', reprinted in Hayek (1935, ed), Collectivist Economic Planning, Routledge, London, pp. 87-130.
[77] For more on this see: Andrzej Walicki (1988) 'Karl Marx as Philosopher of Freedom', Critical Review, Volume 2, Number 4, pp. 10-59.
[78] This of course is the scenario envisioned in orthodox Marxism.
[79] Mises (1935 [1920]), op.cit., p. 89.
[80] Ibid, p. 93.

"...be impossible to determine its monetary value".[81]

Mises contended that under the anarchic organisation of classical economics, market prices acted as "aids to the mind".[82] Although not able to account for perfection, monetary calculation does at least facilitate the practical co-ordination of highly intricate production processes. The existence of highly subjective market prices enables each decision maker to take into account much information, which – absent such prices – they could not possibly be aware of.

Remove the assistance provided by such 'aids to the mind' and Mises argued that the human mind would be unable to "orient itself properly among the bewildering mass of intermediate products and potentialities of production."[83] For him, the exchange ratios that emerged in the course of market exchange, facilitated a type of "intellectual division of labour" that allowed those participating in trade to draw upon each other's knowledge in an indirect manner.

Of the vast array of projects that are technically feasible at any particular point in time, only a small number are likely to prove 'economically rational' over the longer term. Therefore, if available resources are to be utilised effectively, it is vital that those in charge of production possess have some method that enables them to discriminate between the various methods in which factors can be combined, eliminating those which are considered uneconomic. Mises argued that the human mind alone "is too weak to grasp the importance of any single one among the countlessly many" factors.

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[81] Ibid.
[82] Ibid., 102.
[83] Ibid., 103.

> "No single man can ever master all the possibilities of production, innumerable as they are, as to be in a position to make straightway judgements of value without the aid of some system of computation."[84]

Those in charge of industrial production under socialism and centrally planned systems have need of a surrogate for the price system. That is, a surrogate aid to mind capable of guiding them through the plethora of potential factor combinations; a guide through the "oppressive plenitude of economic potentialities".[85] For Mises, central planners and Marxists are the unreasonable[86] in pursuit of the unfeasible.

Its unfeasibility had been strongly hinted at by Frederich von Wieser in 1889, N. G. Pierson in 1902, Enrico Barone in 1908. However, it took until 1920 for it to be explained in detail by Mises.

One of Mises student's, Friedrich Von Hayek, elaborated still further honing and refining the position. For Hayek, the problem of economic calculation as it confronts a factor manager – which was Mises's original concern – can best be interpreted as the surface manifestation of a deeper underlying 'knowledge problem'. As Andrew Farrant has commented:

> "An individual producer is faced with the problem of coordinating his activities with those of N other economic agents; his decision making process must take account of a vast plethora of esoteric detail, relating to matters concerning his factor inputs, the relative cost of potential substitutes, and so forth – 'details' that are widely dispersed throughout the global productive structure. The vast majority of this 'knowledge' is unavailable to any producer in an easily accessible form. No producer

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[84] Ibid., 102.
[85] Ibid., 101.
[86] See: David Ramsay Steele (1992) From Marx to Mises: Post-Capitalist Society and the Challenge of Economic Calculation, Open Court, La Salle, Illinois, p. 375. Steele contends that if Marxism had been "more unabashedly utopian, it would not have had the same motive to evade discussions of the mechanics of its proposed future society. The attempt to abstain from utopianism merely leads to unexamined utopias." Moreover, he continues, there is "no escape from utopianism, other than mute abstentionism. But we can criticize our utopias, discard those convicted of unfeasibility, and replace them with better utopias. Wishful thinking is no vice, but openness to argument is a wonderful virtue."

can know – it being an epistemological impossibility – every intricate facet relating to the manufacture (or extraction, in the case of raw materials) of his factor inputs. Yet, as Hayek's opponents readily admitted, such detail must be taken into account, if production is to proceed in a sensible manner."[87]

To illustrate this point, Hayek recounts a story about the market for tin. Providing an overview of the story, Farrant continues:

"The price of tin reflects (admittedly, in a less than ideal way) a vast plethora of detail, that cannot by its nature be 'known' to those for whom tin serves as a factor input. The price of tin reflects – encapsulates – factual detail pertaining to: the supply of tin; various demands for it as an industrial input; the various supply and demands for tin substitutes; the costs of producing tin; factors relating to tin complements; and so forth *ad infinitum*. By reference to the price of tin, a producer – problems of signal-extraction notwithstanding – can adapt his activities to a change in any of the various factors enumerated above. An increase in the price of tin – due perhaps, to a decrease in the supply of a tin substitute, an increase in the demand for tin, or a strike at a tin mine – will have the result that tin users will be made aware that it is now necessary to utilise tin more sparingly; perhaps – in the case of a marginal usage – foregoing the use of tin entirely."[88]

Having encountered the Austrian School of Economics and Von Mises in 1922, and being profoundly affected by their anti-socialist teachings, Hayek spent much of the rest of his life exploring the truths of the school's teachings.

Overall, the Austrian School of Economics sees society as a web of complex human interactions in which prices act as signals for human behaviour:

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[87] Andrew Farrant, The Socialist 'Calculation' Debate: Lange Versus Mises and Hayek, Economic Notes No. 71, Libertarian Alliance, London, p. 3.
[88] Ibid.

> "For the 'Austrian economist' the free market and the language of price are the very sources and mechanisms of wealth, the diversity of goods produced by many individuals is richer and more useful, ensuring greater and more widespread wealth than any system which attempts to control from the centre. A diversity of different attempts to predict future needs is what guarantees innovation. The role of market pricing is partly that of allocating resources to the preferred use. Its more important role however, is that of transmitting information about preferences and about relative scarcities. Only markets can effectively utilise information dispersed throughout millions of economic agents. Profit is a signal which demonstrates that the entrepreneur is doing the right thing for people he cannot know. Price is therefore the language of the complex or extended order of modern societies. The knowledge utilised in this extended order is greater than that which any single agent such as a government department can possibly acquire."[89]

Hayek's 'Austrian' theory has three fundamental strands. The primacy of individual freedom, the value of the market mechanism and the assertion that 'social justice' is not only fruitless – because there is no such thing – but actively harmful, because it can and will end up by destroying individual freedom.

For Hayek, the market has been historically beneficial to humanity because it is efficient and it protects individual choice and freedom:

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[89] Graham, D., and Clarke, P., (1986) The New Enlightenment, Macmillan, London, in association with Channel 4, p. 7. For more information on Austrian Economics see the following works. Barry, N. P., (1979) Hayek's Social and Economic Philosophy, Macmillan, London. Butler, E., (1983) Hayek: His Contribution of the Political and Economic Thought of our Time, Hounslow, Temple Smith. Dolan, E. G., (ed) (1976) The Foundations of Modern Austrian Economics, Sheed and Ward, Kansas City. Friedman, M (1962) Capitalism and Freedom, The University Press, Chicago. Friedman, M and Friedman, R., (1980) Free to Chose, Penguin Books, Harmondsworth. Grassl, W. and Smith, B., (eds) Austrian Economics, Croom Helm, London. Hayek, F. A., (1980) Individualism and Economic Order, University of Chicago Press, Chicago. Hayek, F. A. (1984) Money, Capital and Fluctuations, edited by R. McCloughry, Routledge, London. Kirzner, I., (1986) Subjectivism, Intelligibility and Economic Understanding, Macmillan, London. Mises, L., von (1966) Human Action, 3rd revised edition, Contemporary Books, Chicago. Mises, L., von (1978) Ultimate Foundations of Economic Science, Sheed, Andrews and McMeel, Kansas City. Mises, L., von (1981) Socialism, Liberty Fund, Indianapolis. Rothbard, M. N., (ed.) (1987) The Review of Austrian Economics, Vol. 1, D. C Heath, Lexington, Massachusetts. Spadaro, L. M., (ed) (1978) New Directions in Austrian Economics, Kansas City, Sheed, Andrews and McMeel.

> "[It is] a procedure which has greatly improved the chances of all to have their wants satisfied. It is the only procedure yet discovered in which information widely dispersed among millions of men can be effectively utilised for the benefit of all – and used by assuring to all an individual liberty desirable on ethical grounds."[90]

While exponents of the free market from William Goodwin to Friedrich Hayek, defended the free market on the basis of its overall social product and its capacity to create wealth and prosperity for all, the American philosopher and novelist Ayn Rand provided a uniquely moral, ethical and epistemological defence of capitalism. For her:

> "The moral justification of capitalism does not lie in the altruist claim that it represents the best way to achieve 'the common good'...the moral justification of capitalism lies in the fact that it is the only system consonant with man's rational nature, that it protects man's survival qua man, and that its ruling principle is: Justice."[91]

What makes Rand's promotion of capitalism and genuinely free markets unique is – as Douglas J. Den Uyl and Douglas B. Rasmussen[92] have argued - that it neither considers capitalism a necessary evil (as do many Conservatives), nor does she attempt to defend it in terms of ends (as do many economists). Instead, the essence of capitalism is individual rights: if individual rights are respected, then that society is capitalist. To understand Rand's theory of rights one must not only grasp her ethical doctrine, but also her fundamental philosophy of man.

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[90] Friedrich von Hayek, (1976) Law, Legislation and Liberty, Vol. 2., The Mirage of Social Justice, Routledge and Kegan Paul, pp. 70-71.

[91] Rand, A., (1967) 'What is Capitalism' in Capitalism the Unknown Ideal, New American Library, New York, p. 20. See also: Branden, N., and Branden, B., (1964) Who Is Ayn Rand? Paperback Library, New York; Branden, B., (1986) The Passion of Ayn Rand, W. H. Allen & Co, London. Branden, N., (1985) Judgement Day: My Years with Ayn Rand, Houghton Mifflin, New York. Mevrill, R. E. (1991) The Ideas of Ayn Rand, Open Court, Lasalle, Illinois.

[92] Den Uyl, Douglas and Rasmussen, D. B., (eds) (1986) The Philosophical Thought of Ayn Rand, Illinois University Press, Illinois, p. 166.

Based on an essentially Aristotelian model of human action, Rand's conception of man emphasises the creative power of the human mind. The degree to which one's knowledge increases is argued to be a function of one's ability to solve problems effectively. Against the claims of determinism and the purveyors of over-socialised models of human action, Rand argues there is no static set of rules that if followed will lead automatically to new insights into a given problem. In both her fictional and non-fictional works the creative mind is identified as the dynamic, inspirational force behind all human progress:

> "Men of genius in both the sciences and the arts are those who do not allow themselves to be held down by received wisdom."[93]

Under Rand's philosophy, popularly known as Objectivism because of its Aristotelian-realist epistemological and metaphysical views on objective reality, the fundamental alternative facing living things is productive or destructive action. In the case of human beings, those courses of action necessary for the furtherance of our existence are not automatically determined, but chosen. Because we have no automatic means for the furtherance of our lives, we are forced to make choices about which course(s) of action to take. Therefore, the volitional nature of Man's consciousness implies *a priori* a principle of freedom. To act as if there is some substitute for this volitional feature of human nature is to contradict a fundamental metaphysical fact about our nature. Capitalism is not merely "a social system based on the recognition of individual rights",[94] but more importantly, "it is the basic metaphysical fact of man's nature – the connection between his survival and his use of reason – that capitalism recognises and protects".[95]

Rand defines reason as the ability to conceptualise material provided by the senses. She argues that our very survival requires that we conceptually attend to the empirical world. Ultimately, human choice rests upon whether to

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[93] Ibid., p. 166.
[94] Rand, A., Capitalism the Unknown Ideal, op.cit., p. 322.
[95] Ibid.

direct our full attention to the situations we experience or to base perception on whim; the universe according to Rand being intelligible and potentially understandable.

In *For the New Intellectual* she uses two philosophical ideal types to depict the enemies of rationality and therefore capitalism; the Witch Doctor and Attila.

> "The essential characteristic of these two remain the same in all ages: Attila, the man who rules by brute force, acts on the rage of the moment, is concerned with nothing but the physical reality immediately before him, respects nothing but man's muscles, and regards a fist, a club or a gun as the only answer to any problem..."[96]

The Witch Doctor, or the Kantian philosopher, wishes to avoid empirical evidence and the world of demonstrable reality:

> "[He is] the man who dreads physical reality, dreads the necessity of practical action, and escapes into his emotions, into visions of some practical realm where he wishes to enjoy a supernatural power unlimited by the absolute of nature."[97]

For Rand, both the Witch Doctor and Attila exist with a "consciousness held down to the perceptual method of functioning, an awareness that does not choose to extend beyond the automatic, the immediate, the given, the involuntary, which means: an animal's epistemology, or as near to it as a human consciousness can come."[98]

> "It is against the faculty of reason that Attila and the Witch Doctor rebel. The key to both their souls is the longing for the effortless, irresponsible, automatic consciousness of an animal. Both dread the necessity, the risk and the responsibility of rational cognition. Both

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[96] Rand, A., (1961) For the New Intellectual, New York, Signet Books, p. 14.
[97] Ibid.
[98] Ibid.

> dread the fact that 'nature, to be commanded, must be obeyed.' Both seek to exist, not by conquering nature, but by adjusting to the given, the immediate, the known."[99]

Rand's theory of rights is inextricably linked to her conception of human nature. For her, "the source of rights is man's nature."[100] "Rights are a necessary condition of [man's] particular mode of survival."[101]

> "Thus for every individual, a right is the moral sanction of a positive of his freedom to act on his own judgement, for his own goals, by his own voluntary, uncoerced choice. As to his neighbours, his rights impose no obligation on them except of a negative kind; to abstain from violating his rights."[102]

Life and health is not guaranteed. In recognition of this metaphysical fact Rand holds that rights are freedoms of action and not guarantees of anything. Property rights are not conceived by her to be rights to things, but only the freedom to pursue courses of action with respect to material goods. If certain goods and services are to be guaranteed to individuals – as welfare rights theorists demand – some people, by implication, must be coerced to provide for others. Apart form the fact that what is guaranteed is conditional upon the productivity of some (and hence no guarantee at all), there is in principle no limit to what one could claim must be guaranteed.

> "But this view of rights makes a mockery of the notion of a guarantee; for if there is no object to which one may not claim a right, then we could conceivably ask the state to guarantee all things equally, to everyone."[103]

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[99] Ibid., p. 15.
[100] Rand, A., Capitalism the Unknown Ideal, op.cit., p. 322.
[101] Ibid.
[102] Ibid.
[103] Den Uyl, Douglas., and Rasmussen, D. B., The Philosophical Thought of Ayn Rand, op.cit., p. 169.

In one fell swoop, the NHS and notions of state healthcare become not merely ineffective – Hayek's ground for opposition – but actually a fraud. The NHS's demand for 'more resources' can be dismissed as part of a gang of 'looters' fighting over the pickings. To turn a Socialist slogan on its head – healthcare is a privilege and not a right.

Moreover, libertarians complain that few reasons are ever given by welfare theorists as to why the inherently coercive apparatus of the state should be the vehicle for providing certain goods to classes. It is not enough to assume blindly – *a priori* – that the state should, let alone could, provide the goods demanded. For Randians the question is: why are acts of force by the state not subject to the levels of moral condemnation we apply to individuals who take such actions?

Here, the NHS and the welfare state's conception of rights is regarded as being explicitly discriminatory:

> "That conception of rights demands that the state treat some individuals differently from others, depending on their particular status in society at a particular time (e.g., whether they are rich or poor)."[104]

Libertarians argue that, despite socialist and social democratic rhetoric, welfare rights do not suppose that people possess rights. Rather, rights are gifts of the state, and therefore this means that like all benefactors the state possesses the power to remove its generosity when it so desires. Because the state is ultimately is own arbiter it has no obligations to respond efficiently to demand. Because in reality no natural, automatic guarantees are given that mean people will lead successful lives, the NHS and other forms of state welfare are identified as being metaphysical frauds. Modern consensual health economics distorts the true nature of social existence.

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[104] Ibid.

For Rand the best we can do is to establish conditions which will allow for choices that are essential for the pursuit of life. To establish these conditions without reference to anyone's particular circumstance is to treat each individual equally.

Therefore, for her, property rights essentially mean the right to certain courses of action – rather than to particular objects. Property rights are primarily articulated as the right to life; the right of an individual to pursue specific courses of action he thinks best, at any particular time; provided that he does not interact coercively with others:

> "The right to life is the source of all rights – and the right to property is their only implementation. Without property rights, no other rights are possible. Since man has to sustain his life by his own effort, the man who has no right to the product of his effort has no means to sustain his life. The man who produces while others dispose of his product is a slave."[105]

Ayn Rand would no doubt agree, though from an opposing view-point, with Mao's statement that 'all political power grows out of the barrel of a gun'.

At the centre of her Objectivist paradigm is the view that because men are physical entities who require material goods to sustain their very existence, the creation, use and disposal of material things must be permitted. Rand holds that as individuals alone act, and that therefore collectivities are by definition antithetical constructs, collectivities posses no rights. Thus, as rights specify freedom of action and collectivities do not act, property rights can be possessed only by individuals. Although individuals can form groups, and agree to be treated as if they were one, as in the case of a corporation, this does not remove us from the truth that rights ultimately belong to individual human beings. Therefore, property rights demand firstly that individuals must

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[105] Rand, A., Capitalism the Unknown Ideal, op.cit., p. 20. See also: Den Uyl, D. and Rasmussen, D. B., (eds) The Philosophic Thought of Ayn Rand, op.cit, p. 174.

not be kept from seeking material goods, and secondly that they must be free to utilise the goods they have freely acquired.

For Rand, the fact that capitalism involves the pursuit of self-interest is not only correct but morally virtuous. Objectivists and libertarians in general argue that capitalism induces, through the process of individual rational self-interest, material and conditional advancement.

> "Whatever one's line of work, a competitive and free market tends to push one toward the achievement of the best one is able to produce within a given context. Because there are no guarantees that past achievements will not be bettered, there are strong incentives to continue to produce at the maximum level. Moreover, those who are innovative and hard-working are not held to the level of the mediocre and the slothful, since there is the full expectation of reaping the rewards of one's efforts. In short, capitalism is a system directed toward achievement."[106]

Rand maintained that competition is not the law of the jungle. The motto "dog-eat-dog", she wrote "is not applicable to capitalism nor to dogs".[107]

> "Competition is not a zero-sum game where someone wins and another loses, such that there is no overall gain between parties. Competition is rather a method of co-ordinating activities in which those who are most efficient at utilising a given resource are in a position to do so. A kind of human ecological balance is promoted by the market. An economy of resources develops with the result that the appropriate quantity of goods of optimal quality are directed into those areas where they are most needed or desired."[108]

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[106] See: Rand, A., Capitalism the Unknown Ideal, op.cit., p. 20. See also: Den Uyl, D., and Rasmussen D. B., (eds) The Philosophic Thought of Ayn Rand, op.cit., p. 174.
[107] Rand, A., (1964) The Virtue of Selfishness, New American Library, New York, p. 34.
[108] Den Uyl, D., and Rasmussen D. B., (eds) The Philosophic Thought of Ayn Rand, op.cit., pp. 174-175.

Countering the Marxist argument that progress under capitalism is the result of exploiting the surplus labour of workers, Rand contends that capitalism today removes sacrifice from human interaction. The popular belief that capitalism exploits workers is contested in the strongest terms. Collectivism, in whatever variety, is a system wherein some are sacrificed for the sake of others. At the root of collectivism's sacrificial nature is the willingness to operationalise the holistic 'needs of society' view and thereby override individual interests:

> "The social theory of ethics substitutes 'society' for God – and through it claims that its chief concern is life on Earth, it is not the life of man, not the life of an individual, but the life of a disembodied entity...the collective. As far as the individual is concerned, his ethical duty is to be the selfless, voiceless, rightless slave of any need, claim or demand asserted by others."[109]

For Rand, surplus – or profit – is the product of individuals, not a class phenomenon. In a capitalist society no one is coerced to associate with other individuals if one finds it detrimental to personal interests. This is not to deny that difficult choices or disagreeable situations cannot be avoided. But capitalism holds the promise that the products of one's own efforts will not be expropriated without one's agreement.

In British Conservative Party circles, reaction to Rand's philosophy mirrors an ideological tension between two prominent post-war factions: traditionalists (the old Tory right) and the free marketeers (the 'new right'). Traditionalists who essentially regard Christianity as the moral basis of Western culture view Rand's notions of self interest, ethical egoism and laissez-faire capitalism as the highway to hell. These 'witch doctors' treat the free market as a natural enemy of their worldview. In America, Rand's criticism of altruism and her praise of capitalism have been considered as part of the anti-religious message of philosophical materialism and therefore scorned by many

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[109] Rand, A., The Virtue of Selfishness, op.cit., p. 34.

sections of the establishment – including some elements of the Conservative right.

Going further than Rand, but largely based on her neo-Aristotelian natural-law philosophy, the American anarcho-capitalist Murray Rothbard rejects all forms of statism. Criticising democracy, he begins by arguing:

> "...the identification of the State with society has been redoubled, until it is common to hear sentiments expressed which violate virtually every tenet of reason and common sense: such as 'we are the government'. The useful collective term 'we' has enabled an ideological camouflage to be thrown over the reality of political life...If 'we are the government,' then anything a government does to an individual is not only just and untyranical; it is also 'voluntary' on the part of the individual concerned...Under this reasoning, any Jews murdered by the Nazi government were not murdered; instead, they must have 'committed suicide', since they were the government (which was democratically chosen), and therefore anything the government did to them was voluntary on their part."[110]

In differentiating between politics (the State) and the market, Rothbard draws upon the work of the German sociologist Franz Oppenheimer:

- "[he] pointed out that there are two mutually exclusive ways of acquiring wealth...one he called the 'economic means'. The other way is simpler in that it does not require productivity; it is the way of seizure of another's goods or services by the use of force and violence. This is the method of one sided confiscation, of theft of the property of others. This is the method which Oppenheimer termed 'the political means' to wealth. It should be clear that the peaceful use of one's reason and energy in production is the 'natural' path for man: the means for his survival and prosperity on earth. It should be equally clear that the

[110] Rothbard, M. N., 'The Anatomy of the State' in Rampart Journal of Individualist Thought, Vol. 1, No.2, Summer, 1965.

> coercive, exploitative means is contrary to natural law; it is parasitic, for instead of adding to production, it subtracts from it. The 'political means' siphons production off to a parasitic and destructive individual or group; and this siphoning not only subtracts from the number producing, it also lowers the producer's incentive to produce beyond his own subsistence. In the long run, the robber destroys his own subsistence by dwindling or eliminating the source of his own supply. But not only that; even in the short run, the predator is acting contrary to his own true nature as a man.[111]

For Rothbard, states and political systems have never been created by 'social contract', they are born out of conquest and force. Yet he argues that to retain power, rulers have to gain the support of a majority of subjects in the long run, otherwise they run the risk of being out-weighed by the active resistance of the majority. A state's support need not take the form of active enthusiasm. It may well amount to passive resignation as if to an inevitable law of nature. Transposing Marx's dominant ideology thesis, he argues that:

> "...the chief task of the [State's] rulers is always to secure the active or resigned acceptance of the majority of the citizens."[112]

And one method of obtaining it is through the creation of vested interest groups:

> "...the king alone cannot rule; he must have a sizable group of followers who enjoy the prerequisites of rule, i.e., the members of the state apparatus, such as the full-time bureaucracy of the established nobility. But this still secures only a minority of earlier supporters...the majority must be persuaded by ideology that their government is good, wise, and, at least, inevitable, and certainly better than other conceivable alternatives. Promoting this ideology among the people is the vital social task of the 'intellectuals'. For the masses of men do not

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[111] Ibid. See also: Oppenheimer, F., (1926) The State, Vanguard Press, New York, pp. 24-27.
[112] Ibid.

> create their own ideas, or indeed think through these ideas independently; they follow passively the ideas adopted and disseminated by the body of intellectuals. The intellectuals are therefore the 'opinion-moulders' in society. And since it is precisely a moulding of opinion formers that the state almost desperately needs, the basis for the age-old alliance between the state and the intellectuals becomes clear."[113]

In Rothbard's *For a New Liberty*, an 'anarcho-Capitalist manifesto' is presented. It starts with the view that market economics does not emanate from the Left or the Right. Because libertarians view conscription as a form of mass slavery and believe in the individual's absolute right to be 'free' from aggression, they stand foursquare with the 'civil liberties' left in supporting: the freedom to speak, publish, assemble and engage in such 'victimless crimes' as pornography, sexual deviation, and prostitution. On the other hand, since libertarianism opposes the violation of property rights and emphatically opposes government interference in the economy, this world view is inextricably tied to a system of laissez-faire capitalism which is popularly thought of as right wing.

In terms of political economy, Rothbard is an eclectic, yet coherent and consistent thinker. He argues for nothing less than one global market, devoid of states and formal political institutions.

As an anarcho-capitalist he rejects the statist institutions traditionally favoured by many mainstream and consensual democratic politicians. For him, state services such as health and education are nothing more than a 'middle class hoax'.[114]

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[113] Ibid.

[114] With state education, for example, Rothbard complains: "Part of the reason for this tyranny...is misplaced altruism on the part of the educated middle class. The workers, or the 'lower classes', they felt, should have the opportunity to enjoy the schooling the middle classes value so highly. And if the parents or the children of the masses should be so benighted as to balk at this glorious opportunity set before them, well, then a little coercion must be applied – 'for their own good, of course'." For him, education is a lifelong process of learning that should be organised privately and therefore without state coercion. See: Rothbard, M. N., (1973) For a New Liberty, The Macmillan Publishing Company, New York, pp. 132-133.

One follower of Rothbard and a fellow anarcho-capitalist, Hans-Hermann Hoppe,[115] produced a paper analysing market failure in health systems. It was called '*A Four-Step Health-Care Solution*'.[116] Arguing that the American health care system is "a mess",[117] and that "this demonstrates not market but government failure",[118] he commences by asserting:

> "To cure the problem requires not different or more government regulations and bureaucracies, as self-serving politicians want us to believe, but the elimination of all existing government controls...It's time to get serious about health care reform. Tax credits, vouchers, and privatisation will go a long way towards decentralizing the system and removing unnecessary burdens from business. But four additional steps must also be taken."[119]

For Hoppe, point one requires the abandonment of state regulatory controls and market interventions in favour of a purer market driven by reputation and meaningful competition.

> "Eliminate all licensing requirements for medical schools, hospitals, pharmacies, and medical doctors and other health care personnel. Their supply would almost instantly increase, prices would fall, and a greater variety of health care services would appear on the market...Competing voluntary accreditation agencies would take the place of compulsory government licensing. If health care providers believe that such accreditation would enhance their own reputation,

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[115] For Hoppe's main works see: Hoppe, H., (2002) Democracy: The God That Failed, Transaction, New Brunswick, New Jersey; Hoppe, H., (1995) Economic Science and the Austrian Method, Ludwig von Mises Institute, Auburn, Alabama. Hoppe, H., (1993) The Economics and Ethics of Private Property: Studies in Political Economy and Philosophy, Kluwer Academic Publishers, Boston. Hoppe, H., (1989) A Theory of Socialism and Capitalism: Economics, Politics and Ethics, Kluwer Academic Publishers, Boston. Hoppe, H., (ed) (2002) The Myth of National Defense: Essays in the Theory and History of Security Production, Ludwig von Mises Institute, Auburn, Alabama.

[116] Hans-Hermann Hoppe, 'A Four-Step Health-Care Solution', The Free Market, April 1993, Volume 11, Number 4, Ludwig von Mises Institute, Auburn, Alabama.

[117] Ibid., p.1.

[118] Ibid.

[119] Ibid.

and that their consumers care about reputation, and are willing to pay for it. Because consumers would no longer be duped into believing that there is such a thing as a "national standard" of health care, they will increase their search costs and make more discriminating health care choices."[120]

Point two demands that the state completely withdraws from pharmaceuticals and medical devices.

"Eliminate all government restrictions on the production and sale of pharmaceutical products and medical devices. This means no more Food and Drug Administration, which presently hinders innovation and increases costs...Costs and prices would fall, and a wider variety of better products would reach the market sooner. The market would force consumers to act in accordance with their own - rather than the government's – risk assessment. And competing drug and device manufacturers and sellers, to safeguard against product liability suits as much as to attract customers, would provide increasingly better product descriptions and guarantees."[121]

Hoppe continues with point three which asserts that government should completely deregulate and open up to real consumer choices the private medical insurance market.

"Deregulate the health insurance industry. Private enterprise can offer insurance against events over whose outcome the insured possesses no control. One cannot insure oneself against suicide or bankruptcy, for example, because it is in one's own hands to bring these events about...Because a person's health, or lack of it, lies increasingly within his own control, many, if not most health risks, are actually uninsurable.

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[120] Ibid.
[121] Ibid.

> "Insurance" against risks whose likelihood an individual can systematically influence falls within that person's own responsibility."[122]

He continues:

> "All insurance, moreover, involves the pooling of individual risks. It implies that insurers pay more to some and less to others. But no one knows in advance, and with certainty, who the "winners" and "losers" will be. "Winners" and "losers" are distributed randomly, and the resulting income redistribution is unsystematic. If "winners" or "losers" could be systematically predicted, "losers" would not want to pool their risk with "winners," but with other "losers", because this would lower their insurance costs. I would not want to pool my personal accident risks with those of professional football players, for instance, but exclusively with those people in circumstances similar to my own, at lower costs."[123]

In attacking the damaging failings of legislative favour in American health insurance, Hoppe also highlights the distortions that lie behind this most corporatist and politicised of sectors.

> "Because of legal restrictions on the health insurers' right of refusal – to exclude any individual risk as uninsurable – the present health-insurance system is only partly concerned with insurance. The industry cannot discriminate freely among different groups' risks...As a result, health insurance cover a multitude of uninsurable risks, alongside, and pooled with, genuine insurance risks. They *do not* discriminate among various groups of people which pose significantly different insurance risks. The industry thus runs a system of income redistribution – benefiting irresponsible actors and high-risk groups at the expense of responsible individuals and low risk groups. Accordingly the industry's prices are high and ballooning. To deregulate the industry means to

[122] Ibid., pp. 1-2.
[123] Ibid., p.2.

> restore it to unrestricted freedom of contract: to allow a health insurer to offer any contract whatsoever, to include or exclude any risk, and to discriminate among any groups of individuals. Uninsurable risks would lose coverage, the variety of insurance policies for the remaining coverage would increase, and price differentials would reflect genuine insurance risks. On average, prices would drastically fall. And the reform would restore individual responsibility in health care."[124]

Finally, Hoppe argues for the de-nationalisation of health and welfare funding in an attempt to guard against the moral hazards associated with government resources.

> "Eliminate all subsidies to the sick or unhealthy. Subsidies create more of whatever is being subsidized. Subsidies for the ill and disabled breed illness and disease, and promote carelessness, indigence, and dependency. If we eliminate them, we would strengthen the will to live healthy lives and to work for a living. In the first instance, that means abolishing Medicare and Medicaid."[125]

At the end of Hoppe's analysis and promotion of a real market in medicine and health care, he asserts that:

> "Only these four steps, although drastic, will restore a fully free market in medical provision. Until they are adopted, the industry will have serious problems, and so will we, its customers."[126]

For David Friedman, the leading anarcho-capitalist and author of *The Machinery of Freedom*,[127] goods and services are produced and allocated in several different ways. In addition to the market there is household production

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[124] Ibid.
[125] Ibid.
[126] Ibid.
[127] David Friedman, (1978) The Machinery of Freedom: A Guide to Radical Capitalism, Chicago, Open Court Publishing.

– which is the way in which children are reared, homes cleaned, clothes washed, and most meals cooked. There is also political production.[128]

While household production represents a substantial fraction of the economy, and perhaps even of total medical services (for example, parents serving as nurses for their sick children, grown children taking care of aging parents) Friedman's work is primarily concerned with the production and allocation on the market and production and allocation by government. The main question he tries to answer is whether one form of production should be preferred, and if so which? In his '*Should Medicine be a Commodity?'* Friedman comments:

> "Economic efficiency is a strong requirement for the outcome of any real world system of institutions, since an outcome is efficient only if it could not be improved by a bureaucrat god – a benevolent despot with perfect information and unlimited power over individual actions. While it may be seen as an upper bound on how well an economic system can work, one might think that using that bound to judge real systems is as appropriate as judging race cars by their ability to achieve their upper bound – the speed of light".[129]

For him, it is one thing to show that there is something government could do that would improve on the outcome of the unregulated market and another entirely different and much more difficult matter to show that what government would actually achieve given the power would improve on that outcome:

> "That would require a theory of governmental behaviour comparable in power and precision to the theory of market behaviour from which the original efficiency theorem, and the inefficiencies due to failures of its assumptions, were derived. No widely accepted theory of that sort exists, and much of the large and growing literature that attempts to

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[128] Friedman speculates that it is even not clear that the market represents a larger part of the total economy than alternative ways.

[129] David Friedman, 'Should Medicine be a Commodity?' published on-line at: http://www.daviddfriedman.com/Academic/Medicine_Commodity/Medicine_Commodity.html See page 7.

produce such a theory seems to suggest that government intervention is more likely to worsen than to improve market outcomes."[130]

He suggests that the best analysis available is 'public choice' – or the economics of the political market. Public choice theory attempts to analyse the political system by using the same approach by which ordinary economics analyses the private market.

Crucially, public choice theory applies the techniques of economic analysis - monopoly, competition, information costs – to political and bureaucratic behaviour. It drops the traditional assumption that politicians and bureaucrats try to serve only 'the public interest' and more realistically assumes that, as elsewhere, they try to serve their own interests by re-election and empire-building. The vote motive in politics is akin to the profit motive in industry.[131]

For Friedman, the important question however is not whether the political market works under conditions of zero transaction costs and perfect information – under those assumptions the private market is also perfectly efficient. The really interesting question is how badly each system breaks down when the assumptions are relaxed?

Countering the claim that "health is too important to be left to the market"[132] he retorts:

"My response would be that the market is, generally speaking, the best set of institutions we know of for producing and distributing things. The more important the good is, the stronger the argument for having it produced by the market.

"Both barbers and physicians are licensed; both professions have for decades used licensing to keep their numbers down and their

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[130] Ibid. p.8.
[131] Gordon Tullock, (1976) The Vote Motive, London, Institute of Economic Affairs. James Buchanan (1978) 'The Development of Public Choice', in The Economics of Politics, London, Institute of Economic Affairs. James Buchanan and Gordon Tullock (1962) The Calculus of Consent, University of Michigan Press.
[132] David Friedman, 'Should Medicine be a Commodity?', op.cit., p.42.

> salaries up. Government regulation of barbers makes haircuts more expensive; one result, presumably, is that we have fewer haircuts and longer hair. Government regulation of physicians makes medical care more expensive; one result, presumably, is that we have less medical care and shorter lives. Given the choice of deregulating one profession or the other, I would choose the physicians."[133]

In Britain, Friedman's perspective is echoed in the writings of Brian Micklethwait mentioned in Chapter I. Like Friedman, Micklethwait describes himself as an anarcho-capitalist.[134]

However, whereas in Britain mainstream health economists have traditionally emphasised the particular – unique - nature of health care, arguing that market failure is a real and unavoidable concern to be checked by government, Micklethwait comments:

> "Medicine is often described as special, and it is special. But so are all businesses. Every kind of business has its own unique features which make it unlike any other business. But that doesn't mean that it should not be a business and should instead get special help from the government. The world is full of interest groups who claim that they should get special treatment - car producers, coal minors, lawyers etc.[135]

Perhaps the most widely read free market health policy expert in Britain is Dr. David Green. Formerly the head of the Institute of Economic Affair's Health and Welfare Unit and now the Director of the London based think tank Civitas, he has long championed the debunking of three types of market failure in modern health economics.

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[133] Ibid.
[134] Brian Micklethwait, (1992) Why I Call Myself a Free Market Anarchist and Why I Am One, Political Notes No.67., London, Libertarian Alliance.
[135] Brian Micklethwait in conversation with the author in 2005.

Green argues that professional monopoly power is not inherent in health care, but arises because governments either actively or passively accept it. Professional bodies can exert considerable control when they are granted legislative favour by statute and on behalf of the political class.

Concerning notions of consumer ignorance, Green argues that there is an asymmetry of knowledge in any market where people are paying for the expertise of others – for example, lawyers, mechanics and accountants. But he points out that this does not necessarily preclude the operation of a viable and sustainable market. Instead, he argues that much of the uncertainty faced in health care – particularly in terms of outcomes – exists for clinicians as much for patients. He also observes that consumer ignorance may - in major measure - be due to the highly restrictive practices of health professionals particularly when it comes to health information, advertising and sharing knowledge with patients on issues of access to alternative options.

Concerning the issue of moral hazard, Green points out that in Britain health care is in large measure provided by the public sector and therefore heavily subsidised by the taxpayer. The public sector patient is therefore in the same position as an insured private patient to the extent that payment at the point of service understates the true cost of supplying the service. For Green, this reality means that inflated demand will occur in either sector and that therefore problems of moral hazard inevitably arise in both state and market systems.

The idea however that government is in some way a superior agent, over and above a spontaneous and free market, is increasingly being rejected. For Green, Mises, Hayek, Rand, Rothbard, Hoppe, Friedman, and Micklethwait the very idea of market failure is itself dubious for it imputes upon the market a status of 'absolute perfectionism' that its defenders would never want to claim.

To these writers, health economics can never be addressed in such fixed and absolutist terms as 'failure' or 'success'. Instead, they believe the market is

better and more accurately viewed as a superior process of discovery and of trial and error.

For Friedman the notion of market failure in health economics and its popularity with most opinion formers has arisen because most people:

> "...interpret the problem in terms of fairness rather than efficiency."[136]

Commenting on those people who – often unconsciously - adhere to commonly held notions of market failure in health, he asserts:

> "...they may be making the error of judging a system by the comparison between its outcome and the best outcome that can be described, rather than judging it by a comparison between its outcome and the outcome that would actually be produced by the best alternative system available. If, as seems likely, all possible sets of institutions fall short of producing perfect outcomes, then a policy of comparing observed outcomes to ideal ones will reject any existing system."[137]

In examining the psychology of the health policy debate and the negativity that many people impute upon the market, Friedman concludes that exactly the same concerns can be expressed when it comes to government intervention.

> "It is easy, and satisfying, to pick some unattractive outcome – a poor man, actual or imaginary, turned away from the expensive private hospital that could have cured his disease – and describe it as "intolerable," "unacceptable," or some similar epithet designed to prevent further discussion. This is, however, a game that any number can play. It is equally easy....for the defender of the market to orate about the hundred thousand people who died of heart attacks because

[136] David Friedman, 'Should Medicine be a Commodity'?, op.cit., p.42.
[137] Ibid.

the FDA refused to permit American physicians to prescribe beta blockers to American patients. In a large and complicated society, it is likely that any system for producing and allocating medical care – or doing anything else difficult and important – will sometimes produce outcomes that can plausibly be labelled as intolerable. "[138]

Warning against the political and economic psychology of market failure, Friedman powerfully concludes:

"The question we should ask, and try to answer, is not what outcome would be ideal but what outcome we can expect from each of various alternative sets of institutions, and which, from that limited set of alternatives, we prefer...My conclusion is that there is no good reason to expect government involvement in the medical market, either the extensive involvement that now exists or the still more extensive involvement that many advocated, to produce desirable results."[139]

Notions of Market Failure in Today's NHS Debate

It was John Maynard Keynes who argued that politicians essentially follow in the wake of intellectuals and academic philosophers.[140] In this context, it is perhaps interesting to note a speech the Chancellor of the Exchequer, Gordon Brown, gave to the London based think tank, the Social Market Foundation, in early February 2003.[141]

In it he argued that while the government should increasingly embrace the free market to build a strong economy and a fairer society, healthcare had to remain publicly funded and publicly provided.

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[138] Ibid., p.43.
[139] Ibid.
[140] John Maynard Keynes famously wrote: "The ideas of economists and political philosophers...are more powerful than is commonly understood. Indeed, the world is ruled by little else. Madmen in authority, who hear voices in the air, are distilling their frenzy from some academic scribbler of a few years back."
[141] 3rd February 2003.

Breaking with traditional labour movement thinking to embrace the benefits of a dynamic market economy, the Chancellor began:

> "Instead of being suspicious of competition, we should embrace it, recognising that without it vested interests accumulate....Instead of being lukewarm about free trade, free trade not protectionism is essential to opportunity and security for all and instead of the old protectionism we advocate open markets. Instead of being suspicious of enterprise and entrepreneurs, we should celebrate the entrepreneurial culture – encouraging, incentivising and rewarding the dynamic and enthusing more people from all backgrounds and all areas to start up businesses - here again enabling markets to work better and strengthening the private economy. Instead of thinking the state must take over responsibility where markets deliver insufficient investment and short termisim in innovation, skills and environmental protection we must enable markets to work better and for the longer term....Instead of the old centralisation that characterised industrial policy – promoting 'national champions' or 'picking winners' or offering subsidies to loss makers – our industrial policy should reject special privileges for anyone....Instead of extending regulation unnecessarily to restrict the scope of markets, we should systematically pinpoint services where regulation does not serve the public interest."[142]

However, it was not long before Brown made it clear that there was a limit to his enthusiasm for free markets. He declared that healthcare should not be treated as a "commodity bought and sold like any other".[143]

Arguing that 'essential public services' such as the NHS must remain under the purview of the state he warned that if the market were ever allowed to intervene Labour would be:

> "...unable to deliver a Britain of opportunity and security for all".[144]

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[142] Daily Mail, 'Brown goes for the free market (but not in the NHS)' 4 February 2003, p.2.
[143] Ibid.

Indeed, it was the passion of his resistance to free market reforms in the NHS that stood out from this important speech.

Crucially, he argued that the government's promotion of markets must be combined with a "clear and robust" recognition of their limits. And he highlighted the provision of healthcare as being a primary sector where market forces should not be allowed to operate. He asserted:

> "In healthcare we know that the consumer is not sovereign: use of healthcare is unpredictable and can never be planned by the consumer in the way that, for example, weekly food consumption can. With the consumer unable, as in a conventional market, to seek out the best product at the lowest price, the results of a market failure for the patient can be long-term and catastrophic and irreversible."[145]

He went on to conclude:

> "If we were to go down the road of introducing markets wholesale into our healthcare, we would be paying a very heavy price in efficiency and equity and be unable to deliver a Britain of opportunity and security for all."[146]

In Britain this speech, more than any other of recent times, serves to highlight the popularity of market failure as a fundamental notion deeply embedded in the contemporary healthcare and NHS debate. More than any other speech it exposed for all to see the presumptions and biases of major swathes of the political and intellectual class.

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[144] Ibid.
[145] Ibid.
[146] Ibid.

For the story of the development of notions of market failure in healthcare can be viewed as the establishment of highly restrictive, artificial and ultimately counter-productive boundaries on discourse and debate.

Whilst Tom Paine and Adam Smith might be shocked to learn that their advocacy of state interventionism in education has contributed, in the context of the history of ideas, to the legitimation of unprecedented interventionism in healthcare, the record suggests this to be so.

When it comes to the history of British health care and the NHS, expanded and popular notions of market failure have come to dominate popular mindset and opinion.

Although there is now some evidence to suggest that ideas of 'government failure' are on the ascendant - and might themselves come to triumph in the future healthcare debate – there is clearly a long way to go.

As the historical record of British healthcare, both before the NHS and since its inception suggests, the idea of the development of a real market in healthcare seems a distant – almost utopian – notion itself.

CHAPTER III

THE HISTORY, GROWTH AND EXPERIENCE OF BRITISH HEALTHCARE BEFORE THE NHS

This chapter examines the history, growth and experience of British healthcare prior to the creation of the National Health Service. Away from modern notions of market failure and government intervention, it introduces a much wider history of British healthcare. In beginning to test today's popular and widely held notions of market failure, a wide range of historic evidence and literature is reviewed.

The chapter argues that since Roman times, political elites in Britain have always sought to plan, control and regulate the provision of health services. Through the military, the church, the Royal Colleges, Parliament, and the granting of professional legislative favour in the name of the 'public good', the state has progressively and systematically encroached on every area and facet of healthcare.

Bringing us up to date with the modern world and the inception of the NHS, it argues that by the early 1940s the context in which nationalisation would occur had become compelling and seemingly inevitable.

Tracing the early roots of British healthcare

In the prehistory of the British Isles, healthcare was mainly delivered by various types of shaman or medicine men who were believed to possess supernatural powers. Although there is some evidence that people in prehistoric society were capable of treating minor injuries, such as broken bones, it is also clear that their knowledge of health was extremely primitive. Across the prehistoric and ancient worlds, the idea that gods and sprits caused and cured disease was omnipresent. Unable to explain disease

rationally, through observation and experimentation, people instead chose to invoke gods, demons and spirits in their popular beliefs.[1]

In many forms of medicine at this time, the power of healing was believed to rest with the supernatural powers of the medicine man, who in turn was believed to communicate with the spirit world through trance. Just as the cause of most disease was therefore seen in explicitly supernatural terms, so was its treatment. As a result, priests and temples eventually came to provide the first doctors and hospitals,[2] and much of their work involved the appeasement of the gods through prayer, sacrifice and spells.

Around 400BC, as Greek civilisation developed, notable scientists, mathematicians and writers began to make their mark on the progress of healthcare.[3] Destined to have a profound impact on medicine throughout the British Isles, the most important of these Greek thinkers was Hippocrates. Even to this day he is still popularly referred to as the 'father of modern medicine'.[4]

Hippocrates and his followers are important because they wrote more than sixty medical books and they refused to accept a supernatural view of illness. Instead, they used a secular rationality that stressed observation, diagnosis and treatment.

Hippocrates pioneered a theory which asserted that the human body contained four 'humours': black bile, yellow bile, phlegm and blood. He believed that people became ill when one or more of these humours were out of balance and frequently recommended fresh air, exercise and a sound diet as a core part of treatment.[5]

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[1] John Cule and Roy Porter (2000) The Timetables of Medicine: An Illustrated Chronology of the History of Medicine from Prehistory to Present Times, New York, Blackdog and Leventhal Publishers Ltd; Roy Porter (ed) (1996) The Cambridge Illustrated History of Medicine, Cambridge, Cambridge University Press.
[2] Cule and Porter, Ibid.
[3] Irvine Loudon, (1997) Western Medicine: An Illustrated History, Oxford, Oxford University Press.
[4] Herbert Sam Goldbery (1963) Hippocrates, Father of Medicine, London, Watts
[5] Ibid.

His most important contribution to the development of medicine however was his insistence that his students followed a strict code of ethics when they became doctors. As such, they were made to swear an oath under which they agreed to ensure patient confidentiality and welfare at all times. Even to this day, doctors entering the medical profession in Britain still swear the Hippocratic Oath and as such publicly assert:

> "I swear by Apollo the physician and Aesculapius, and Health, and All-heal, and all the gods and goddesses, that, according to my ability and judgment, I will keep this Oath and this stipulation to reckon him who taught me this Art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture, and every other mode of instruction.
>
> "I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others. I will follow that system of regimen which, according to my ability and judgement, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous.
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> "I will give no deadly medicine to any one if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion. With purity and with holiness I will pass my life and practice my Art. I will not cut persons labouring under the stone, but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further, from the seduction of females or males, of freemen and slaves. Whatever, in connection with my professional service, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad,

> "I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times. But should I trespass and violate this Oath, may the reverse be my lot."[6]

The conjuncture of professional reputation and patient privacy has provided a powerful ethical guide to the practice of medicine down through the ages – although today there is increasing evidence to suggest that politicians and the state are actively seeking to undermine this most sacred of healthcare traditions.[7]

In Britain, it was the Romans who encouraged the dissemination of Greek thinking in healthcare and who constructed the first public network of doctors.[8] Reliant on soldiers to maintain order, build roads and to construct settlements, Rome's political elite understood that healthcare was a vital element in the maintenance of political power and statecraft. Each Roman military fort in Britain had its own medical staff - and sophisticated and sizeable hospitals were built the length and breadth of the country.[9]

However, with the decline of Rome, superstition and religion once again re-emerged to dominate many aspects of public life and thinking. By the middle ages, the Christian church was encouraging the - altruistic - view that it was the duty of all believers to help the sick and needy, and it therefore established a network of monasteries which also acted as hospitals.

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[6] For more on the full text see: http://www.crystalinks.com/gkmedicine.html

[7] Tim Evans and Helen Evans (2001) Big Mother's Deadly New World: How the Government is Going to Destroy Patitent's Health Records and Kill People, Legal Notes No.36, London, Libertarian Alliance.

[8] Lesley Adkins and Roy A. Adkins, (ed) (1994) Handbook to Life in Ancient Rome, New York, Oxford University Press. Karl Christ, (1984) The Romans, translation by Christopher Holme. Los Angeles, University of California Press. (1970) The Oxford Classical Dictionary, 2nd Edition, Oxford, Clarendon Press.

[9] See 'Roman army hospitals' at:
http://www.bbc.co.uk/education/medicine/nonint/prehist/ht/prhtcs1.shtml

Whilst most methods of treating disease remained limited, by 1200 the training of doctors had become formally established. Across the church-controlled universities of Britain and Western Europe, the work of Claudius Galen[10] was being translated from Greek to Arabic and then to Latin.

Galen's (c. AD129-216) work is important because it is indicative of an underlying desire to view medicine through scientific inquiry. Influenced by the work of Hippocrates, Galen discovered that blood moved in the body (although he did not know it circulated) and that a patient's pulse could assist diagnosis.

Nevertheless, throughout the middle ages the Christian church resisted any fundamental degree of scientific explanation or inquiry in healthcare. Dissection, for example, was forbidden until the fourteenth century and even then was only allowed with the express permission of the establishment.[11]

Away from science, the church promoted the idea that god and the devil had direct control over people's health. Frightening epidemics such as the plague or the death of a child were said to be god's punishment for 'sin'. Similarly, disease was popularly believed to be a trial sent by God to cure people of their 'pride'.

Throughout the middle ages, many doctors became increasingly convinced that the movement of the planets directly affected people's health. At one point, astrology became so popular it formed part of doctors' training and when the Black Death struck in 1348, many believed it had been caused by the position of the three planets: Saturn, Jupiter and Mars.[12]

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[10] Jeanne Bendick (2002) Galen and the Gateway to Medicine, New York, Living History Library, Bethlehem Books.

[11] See: http://www.infidels.org/library/historical/andrew_white/Chapter13.html

[12] The Black Death of 1348-50 arrived on a ship that docked at the port of Melcombe in Dorset. On this ship were flea-infested black rats that carried a disease that was to wipe out almost a third of the population of the British Isles. The episode also triggered repeated epidemics over the next three hundred years.

Whilst it was inevitable that such a devastating disease was bound to have a significant impact on medieval society, above all else, the episode serves to highlight the dominant religiosity of the age. This is an excerpt from the text of a letter from the Prior of the Abbey of Christchurch, Canterbury, to the Bishop of London dated 28th September 1348:

> "God often allows plagues, miserable famines, wars and other forms of suffering to arise, and uses them to terrify and torment men and so drive out their sins. And thus the realm of England, because of the growing pride and corruption of its subjects and their numberless sins is to be punished by pestilence."[13]

Most Christians during the middle ages believed that the Black Death was a punishment from God for their sins. They believed that mercy would be given if they could show god how sorry they were for their behaviour and by way of self-punishment many indulged in flagellation. Robert of Avesbury was an eyewitness to such an event. The following account relates to an incident he witnessed in London in 1349:

> "Over 600 men came to London from Flanders, Belgium. They made two public appearances wearing [stockings] from the thigh to the ankle, but otherwise stripped bare. Each wore a red cap with a red cross [painted on it]. Each had in his right hand a scourge [whip] with three tails, sometimes with sharp nails fixed in them. They marched naked in a file and whipped themselves on their naked and bleeding bodies. They would sing hymns and chant prayers as they hit themselves."[14]

In the fourteenth and fifteenth centuries physicians were usually university graduates and had a strong place in the church. The medieval church did not approve of the shedding of blood and gave no encouragement to surgery. As

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[13] See: http://www.bbc.co.uk/education/medicine/nonint/middle/dt/madtcs1.shtml

[14] Robert of Avesbury (1340) De gestis mirabilibus regis Edwardi Tertii, edited by Edward Maunde Thompson, London, Rolls Series 1889 orignial in Latin. Also see: http://www.bbc.co.uk/education/medicine/nonint/middle/am/maamcs2.shtml

a result, the practice of surgery evolved separately from that described as 'physic'.

There was also licensing by the Church. Legislation in 1421 provided that physicians must be approved by universities and surgeons by guilds.[15] Again, in 1511 an Act required the examination of physicians and surgeons and forbade practice by unlicensed persons.[16]

From the late fifteenth century onwards a Renaissance or re-birth of interest in science slowly spread from Italy, across Europe, to Britain. A re-discovery of ancient Greek and Roman texts was combined with a new, more rigorous, approach to the study of science. However, as medicine became more rational and formalised, so its custodians sought to enhance their position in society. This meant they frequently attempted to use the full authority of the state to impose a uniformity of standards on training and qualification – as well as to use other barriers to market entry.[17]

In Britain, advances in scientific and medical thinking fuelled the political establishment's desire to control what as fast becoming a powerful and influential range of disciplines.

With the invention of the printing press, detailed anatomical drawings were being faithfully and economically published and reproduced. For the first time, artists such as Leonardo da Vinci could accurately record their observations, further underpinning and disseminating the scientific method of experimentation.[18]

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[15] See: 'History of the Medical Profession' in Of Germs, Genes and Genocide, (1989) London, United Kingdom Council on Human Rights, p.16.
[16] Ibid.
[17] Penelope J. Corfield, (2000) Power and the Professions, London, Routledge. Also see: David Green, (1985) Which Doctor?: A Critical Analysis of the Professional Barriers to Competition in Health Care, Research Monographs 40, London, Institute of Economic Affairs.
[18] Joanne Snow-Smith, 'Leonardo da Vinci and Printed Ancient Medical Texts: History and Influence', Journal of the Washington Academy of Sciences, Winter 2004, pp2-15.

Throughout the sixteenth century, the scientific method spread and by its end dominated medical thinking. Instead of explaining events and diseases by invoking the supernatural, medical practitioners now began to rely on empirical observation and the development of testable hypotheses.

As medical knowledge expanded, so its practitioners underwent an ever increasing division of labour. This meant that by the end of the middle ages, and the beginning of the renaissance, most surgery in Britain was performed by a clearly identifiable group of specialists known as 'barber-surgeons'.

At the time, doctors were more expensive than barber-surgeons. Indeed, doctors considered surgery to be a menial and inferior task. Home-grown self-help surgery was largely precluded, due to a simple scarcity of sharp instruments in everyday life.

In their everyday work, barber-surgeons used razors to cut people's hair and shave beards. However, they also used these instruments to perform operations such as the extraction of teeth, the lancing of boils, the letting of blood and the setting of fractures. Unlike doctors however, they usually had no formal institutional training and only dealt only with external – and more superficial - problems.

To rectify this situation and to improve their market position, the Company of Barber-Surgeons was created in 1540.[19] It soon attempted to standardise training and treatments - and thereby improve their professional status.

Nevertheless, people who could afford the best medical treatment in England during the sixteenth century avoided these 'traders'. Instead, they went to a member of the Royal College of Physicians, which had been established in 1518.[20]

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[19] Harold Ellis (2002) History of Surgery, Cambridge, Cambridge University Press.
[20] Ibid.

An Act in 1522 granted a monopoly on the practice of physic to those examined and approved by the Royal College – or alternatively by the Universities of Oxford and Cambridge.[21]

The man behind the Royal College of Physicians was Thomas Linacre. He had been one of the few English doctors to travel abroad during this period and had trained in the famous Italian medical centre at Padua - where he eventually became the professor of anatomy.

When Linacre returned to England he became one of Henry VIII's physicians, and it was then that he used his position to obtain a Royal Charter to establish the Royal College. Following the continental model, it was partly a learned academy and partly a guild.

Backed by the full - monopoly - authority of the English state, the college was soon able to specify the qualifications that were required for someone to practise as a physician and therefore what it meant to be one. From this point on, to be a physician in London meant that you had to obtain a license from the college. Indeed, it was not long before this statutory demand was extended to cover physicians across the whole of the country.

In renaissance England, there were essentially three types of medical practitioner: physicians, surgeons and apothecaries. Of these, it was the physicians who used the full force of the state to underpin their market position. Through the monopoly power of legislative favour, physicians were empowered to impose a uniformity of rules and therefore to act explicitly in their own self-interest.

Legislative favour enabled barriers of entry to be erected and soon the college was insisting that their members undergo a rigorous training at university for nothing less than fourteen years. While there was no ultimate guarantee that a

[21] United Kingdom Council on Human Rights, op.cit, p.16.

patient would receive any better treatment from a physician, the college spent a great deal of time trying to discredit its competitors and non-members.

Despite an abundance of evidence that its own recommended treatments were highly ineffective – more often than not, based on the ancient theory of the four humours and blood letting – it is now clear that they frequently exacerbated their patients' symptoms.[22]

Indeed, at the time, their reputation was such that many believed that safer, more effective treatments would be given by a 'wise woman'.[23] Nicknames - such as 'Dr. Slop' and 'Dr. Smell-fungus' - suggest a world that held them in low esteem. In 1665, when the Plague broke out in London, the Royal College of Physicians actually fled London – further undermining their reputation.

Commenting on the inauspicious early history of the College, Dr David Green has noted:

> "For many years the Royal College of Physicians did much to advance medical knowledge, but by the end of the seventeenth century it had lost its commitment to medical advance, and its affairs were being conducted purely in the interests of its members."[24]

He continues:

> "By the late seventeenth century both the Royal College of Physicians and the Barber-Surgeon Company were tending to act in a purely selfish spirit. The great mass of people had no alternative but to turn to the apothecaries."[25]

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[22] For more on this see: http://www.bbc.co.uk/education/medicine/nonint/renaiss/ht/rehtcs2.shtiml
[23] Ibid.
[24] David Green, (1985) Working Class Patients and the Medical Establishment: Self-help in Britain from the Mid-Nineteenth Century to 1948, Gower Publishing, p.34
[25] Ibid.

In the seventeenth century, Charles II attempted to further encourage medical advancement by granting a charter to the Royal Society in 1661. It soon became the centre of scientific activity in London and oversaw an energetic programme of meetings and publications. However, during this period, medicine became even more restrictive. As the state's monopoly power adapted to encompass ever more advances, so its leaders endeavoured to legitimate ever greater political power.

In the world of the seventeenth, eighteenth and early nineteenth centuries, people increasingly turned to 'quack doctors' as the formal medical professions became ever more regulated and therefore expensive. Quacks were popular because, rather like the medical professionals of the day, they too had little idea of what actually caused disease or constituted an effective treatment. In a world that did not yet understand the need for hygiene, people frequently died from surgery and treatment irrespective of who was providing it or the length of the training they had received.

The word 'quack' comes from 'quacksalver', which means someone who sells salves and other healing remedies by fast-talking patter or 'quacking'. Many were not doctors in the eyes of statute but were instead travelling salesmen who went from one village to another. In this world there were so many different ideas about what caused illness that it was difficult to discredit quacks and any other purveyor of poor practice.

It was finally the arrival of apothecaries that enabled people to access better advice and to obtain more effective medical remedies. Quackery was finally weakened when a market in apothecaries spread across the country and most people could therefore gain access to better information on health and medicines in their own communities. Arguably, chemist shops and the arrival of the pharmaceutical industry did more to undermine the bad practice of charlatans than any form of statute or monopoly regulation.[26]

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[26] Ibid.

Throughout the latter stages of the nineteenth century scientific knowledge continued to advance. As the commercial drugs industry sold scientifically proven remedies to customers, so it thrived.

Ultimately, it was the conjuncture of scientific progress and market competition that eroded many of the worst aspects of quackery. However, knowledge, like any tradable commodity or service, is a process of discovery and refinement.[27] As such, there have been many dead-ends that people have travelled down in the history of modern medicine.

For example, the Italian inventor, Luigi Galvani (1737-1798) discovered 'animal electricity'. He discovered that when an electrical charge was passed through an animal's nerves its muscles twitched. Following this, the invention of the electric battery in 1800 by Alessandro Volta brought about a whole variety of popular medical treatments which used electricity. At the time, many people believed that a powerful and 'invisible force' was at hand and that if only it could be harnessed it would contain miraculous medicinal properties.

Whilst electricity can certainly have a beneficial effect in stimulating the heart and pulse rate, early machines were accepted without any evidence of producing positive results. Indeed, up until recent years, electrical shock treatment has been used on many mentally ill patients. Whilst it helped to produce some short-term relief, its longer term consequences seemed negligible, and doctors had little understanding of what it actually did to the brain.[28]

Whilst many developments in medicine come about as a result of professional research, history also demonstrates that progress often comes from people outside the established institutional arrangements.

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[27] Hayek, F. A., (1952) The Counter-Revolution of Science: Studies on the abuse of reason, Glencoe, Illinois, The Free Press.

[28] Peter Breggin, (1991) Toxic Psychiatry, Why Therapy, Empathy and Love Must Replace the Drugs, Electroshock, and Biochemical Theories of the 'New Psychiatry', New York, New York, St. Martins Press.

In Britain, the main pioneer of inoculation for example was Lady Mary Wortley Montague. She had no formal medical training and was instead the wife of the British Ambassador Extraordinary to the Turkish court. She first saw inoculation being successfully used in Istanbul and upon her return to England campaigned for its practice to be adopted. A leading member of London high society, she was able to gradually persuade friends – some of whom were doctors – of the merits of the process. Whilst she was not perhaps a major pioneer in medicine, her example nevertheless serves to underline the point that progress can often come from unexpected quarters.

The first significant step in the fight against infectious disease came in 1796 with the discovery of a vaccine to prevent smallpox. Edward Jenner discovered that milkmaids who had suffered from a mild illness known as cowpox never went on to catch the more serious disease smallpox. To prove the point he experimented on a child by introducing cowpox into its bloodstream. Then, on exposure to the more virulent smallpox the child failed to catch the disease.[29]

Throughout all of this Jenner suffered systematic opposition from the established medical profession.[30] Protected by Royal Charters and barriers to entry, most doctors were able to ignore his ideas and to continue to make good incomes from more established practices of the age.

Similarly, Humphrey Davy in 1799 discovered that the gas nitrous oxide (laughing gas) could dull pain and therefore make operations more comfortable for people.[31] He published a pamphlet to spread the word but to his astonishment found that most surgeons elected simply to ignore his findings.

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[29] Lady Mary Wortley Montagu and Malcolm Jack (ed.) (1993), Turkish Embassy Letters, University of Georgia Press; Cynthia Lowenthal, Lady Mary Wortley Montagu (1994) The Eighteenth-Century Familiar Letter, University of Georgia Press.

[30] 'Edward Jenner' Microsoft (R) Encarta. Copyright (c) 1994 Microsoft Corporation.

[31] David Abbot, (1983) Biographical Dictionary of Scientists - Chemists, New York, New York, Peter Bedrick Books, pp. 35-36.

It was only after a Massachusetts dentist, William Thomas Green Morton,[32] painlessly removed a tumour from a man's neck after giving him ether in 1846 and after James Simpson,[33] the professor of midwifery at Edinburgh University, discovered chloroform in 1847, that the profession eventually shifted their position.

Today, it is often said that British healthcare was organised according to laissez-faire principles between 1830 and 1880. It is similarly held that as the industrial revolution made its mark on society so medicine became an open, market-led, process in which the principles of the anarchic market dominated.[34]

However, in reality, nothing could be further from the truth. Not only was the medical profession seeking ever greater legislative favour from government but the state was itself intervening in ever more areas of medical activity.

Power, Politics and Legislative Favour in the Nineteenth Century

More than in any other previous century, the nineteenth century witnessed an accommodation between the interests of the state and the professions. Essentially a self-reinforcing and mutually beneficial arrangement, the fact is, as Wilding has observed:

> "Professionals depend for their development on state action, whether that action be the organisation of services, the provision of finance or the creation of professional monopolies. Equally, the state needs

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[32] Grace Steele Woodward (1962) The Man Who Conquered Pain, a Biography of William Thomas, Boston, Beacon Press.

[33] Mander, R., (1998) A reappraisal of Simpson's Introduction of Chloroform, Department of Nursing Studies, Edinburgh, University of Edinburgh.

[34] E. J. Evans, (2003) The Forging of the Modern State: Early Industrial Britain, 1783-1870, London, Longman; N. McCord, (1991) British History 1815-1906, Oxford, Oxford University Press; H. Perkin, (1969) The Origins of Modern English Society 1780-1880, London, Routledge; A. Clayre (ed) (1977) Nature and Industrialization, Oxford, Oxford University Press; J.M. Golby (ed.) (1988) Culture and Society in Britain 1850-1890: A Source Book of Contemporary Writings, Oxford, Oxford University Press.

> professionals to fulfil the responsibilities which modern governments assume, to legitimate state power, to make available expertise....The state and the professions need each other, their functions and powers have grown side by side in an alliance at times firm and precarious, explicit and implicit."[35]

In Britain, the Provincial Medical and Surgical Association (PMSA) was founded in 1832 and later became the British Medical Association in 1855.[36] The first organisation to bear the name 'British Medical Association' (BMA) was a rival to the PMSA. The original BMA became defunct within a few years of its foundation, but in the 1830s it was a major rival of the PMSA.

One of the earliest targets of the organised medical profession was the Poor Law. After its reform in 1834 the general feeling among the Poor Law's overseers was that it, and its attendant medical service, had been wastefully administered. This in turn led to considerable tightening up of the system, to which doctors took exception.[37]

In response, the organised medical profession's campaign was led by the original BMA which had two main objections to the new Poor Law.[38] The first was the introduction of tendering for Poor Law medical posts. The second was the Poor Law commissioners' plan to establish independent medical clubs for non-paupers.

Throughout the latter stages of the eighteenth and the early stages of the nineteenth centuries an increasingly rich and diverse tapestry of institutional arrangements developed to provide ordinary people with medical services. They included works clubs, provident dispensaries, medical aid companies, doctor's clubs, and friendly societies.[39]

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[35] Paul Wilding (1982) Professional Power and Social Welfare, London, Routledge and Kegan Paul, p.112.
[36] David Green, op.cit, p. 14.
[37] Ibid.
[38] Ibid.
[39] Ibid., pp. 8-14.

Each type of contract practice was based on the principle of the flat-rate annual contribution, usually payable quarterly, but sometimes weekly or fortnightly, entitling the contributor to any number of consultations during the period covered. Some practices – or clubs – were based at factories while others were organised by charities. Some were run on overtly commercial lines, some by individual doctors, some by local associations of doctors and some by trade union mutuals.

However, a scale of annual capitation fees was proposed in the Poor Law Report of 1836 which substantial elements of the organised medical profession found unacceptable: 3s per single person; 4s per man and wife; 6d per child under sixteen.

The plans were implemented in some areas amidst professional outcry and in many others the BMA persuaded the proponents of the medical clubs to desist. As David Green has noted:

"One of the earliest professional objections to independent medical clubs appeared in April 1837. In a leading article the Lancet opposed a semi-charitable 'penny club' in the Cricklade and Wootton Bassett Poor Law union. And in July the Lancet attacked the penny clubs and self supporting dispensaries then being promoted by Mr. H. L. Smith of Southam. These were objections to the semi-charitable clubs managed on behalf of the poor by the well-to-do, and usually by clergymen. Some doctors also objected to the self-managed friendly society schemes. In 1839, for instance, the Leeds Oddfellows were in dispute with their lodge surgeons, who felt that 2s 6d per year was too low. The Oddfellows responded to the doctors' demands by advertising in London for replacements. Sometimes doctors tried to boycott contract practice altogether. In 1844 in Sunderland there were about sixty clubs with 4,500 members, some paying 2s a year, others 3s. In a pattern which was often to be repeated, thirty-five local GPs joined together to

try and ban contract practice. They only needed two or more colleagues to make the ban effective. But they failed."[40]

In the 1840s and 1850s the organised medical profession not only became increasingly opposed to such clubs but they sought "considerable and immediate reform".[41] They had two main objections. First, they thought the clubs encouraged low pay. Secondly, they wanted to stop them from admitting people who they thought could afford higher fees. On this latter point, doctors sought to exclude the wealthy by imposing an income limit in their rules.[42] In 1845 one correspondent to the Lancet complained that "well-nigh every general practitioner is either immediately or indirectly affected" by the medical clubs.[43] As David Green asserts:

"The chief complaint of the doctors was that they were under-paid. In the 1840s competition was often vigorous and blamed on the overcrowded state of the profession. In Cheltenham in 1848, for instance, one doctor undercut another by nearly 30 per cent, offering to serve a club for 2s 6d per head per year instead of 3s 6d. The BMA put the blame for competition, not on the younger doctor starting out, but on the well-established and wealthy practitioner with a good income who took on assistants to do the club work for a comparative pittance."[44]

Throughout the 1850s strong competition continued between members of the Society of Apothecaries, the Royal College of Surgeons and the graduates of the medical schools. As the number of medical practitioners continued to rise, so it proved more difficult to maintain effective 'professional combinations'[45] at local level.

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[40] Ibid., p. 14.
[41] Ibid., p. 15.
[42] Ibid.
[43] The Lancet, (1851) p. 359.
[44] David Green, op.cit., p. 16. Also see: The Lancet (1849) p. 102; Association Medical Journal, 23 February 1853, pp. 825-6.
[45] David Green, op.cit, pp. 33-62.

As such, many doctors became increasingly frustrated with the failure of their efforts at local combination and instead began to argue for the more vigorous use of the powers of the General Medical Council.

It is the negotiation between professional groups and the state - and the compromises that often result in the heat of negotiation - that often forms some of the most fascinating aspects of public policy. Commenting for example on the 1858 Medical Act, which formally established the General Medical Council, Porter has noted that ultimately it:

> "Proved an ingenious compromise, placating the reformers, protecting the profession and ensuring that in the resultant readjustment of territorial boundaries none of the regular profession came out as losers."[46]

The 1858 Medical Act created the General Medical Council not in place of the existing licensing authorities, but above them. Initially, it had twenty three members, nine nominated by the medical corporations, eight by the universities, and six by the Crown. In 1886, the Crown representatives were reduced to five and five more were added, elected by the general body of practitioners. Usually, the successful candidates were those who enjoyed the support of the BMA.[47]

The power of the GMC resided in the fact that it was required by statute to register persons who could produce a license and pay the fee. The GMC could, however, also remove a doctor from the register on certain grounds.[48] Whilst the GMC was not responsible for training or examinations (and it had no formal power over licensing authorities), if it disapproved of someone it could make representations to the Privy Council which in turn could withdraw its power to issue licenses.

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[46] Roy Porter, op.cit, p.51.
[47] David Green, op.cit.
[48] Ibid.

While it is popularly assumed that all professions are equal, in reality – and to paraphrase George Orwell[49] - some professions are more equal than others, as David Gladstone has recently asserted:

> "In the extensive literature on professions in modern society, it is the medical profession which is seen as the profession *par excellence* and whose defining characteristics – control of entry, specialist training in instrumental skills and a high degree of self-regulation – have become the yardstick against which other occupational groups aspiring to professional status have been assessed."[50]

The 1858 Medical Act marked a turning point in the history of the British medical profession because for the first time it essentially nationalised it. For the first time ever, one single body – the General Medical Council - was charged with overseeing the entire profession and therefore defining in law what it meant to be a doctor. Commenting on this momentous step Nicky Hart has commented:

> "The power of the medical profession lies in its success in having secured by political means, a legal monopoly over the practice of healing in contemporary society. This made the doctor the official expert on health and illness in modern society, a title enshrined in written law. This is the legal-rational basis of medical power. It consists of a monopoly granted by the state, giving the profession exclusive occupational rights, freedom to control the process of recruitment, training and practice and control over the conduct of individual members who each enjoy the right of clinical autonomy. "[51]

As British cities increased in size during the nineteenth century and ever more wealth was created, so the social campaigner Edwin Chadwick popularised

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[49] David Gladstone, op.cit, p.2.
[50] Ibid.
[51] Nicky Heart, The Sociology of Health and Medicine, New York, New York, Causeway Books, p.112.

the notion that the market could never provide solutions in such areas as medicine, sanitation and roads.[52]

As we have seen in the previous chapter, Chadwick's 1842 government report into the health and living conditions of the poor urged a massive increase in state intervention. Under the rubric of 'public health' Chadwick sowed intellectual seeds that simultaneously encouraged a rapid growth in local government and a demand for new forms of interventionism in such diverse areas as drainage, refuse collection, and water purification. Crucially, he also promoted the idea of having tax funded health officers in every British town and city.[53]

In 1875 the government passed the Public Health Act. It demanded that all towns introduce public sector sewerage systems and that they impose a network of local medical officers.

Yet, in a world away from the reality of ever more professional monopoly power and growing government interventionism, Chadwick and his associates continued to argue that the nineteenth century was rampantly capitalist and overtly free market.[54] Seemingly in denial of state sponsored restrictive practices – and such matters as the ever increasing power of the newly formed GMC - they never commented on the potential damage wrought on society by ever increasing state regulation and higher taxes.

Although there were countless examples of emergent private solutions in water supply, sanitation, medicine and healthcare – they became increasingly marginalised as Chadwick conspired with powerful elements of the political, professional and upper-middle classes to further expand the power of political authority.[55]

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[52] Anthony Brundage (1988) England's Prussian Minister: Edwin Chadwick and the politics of government growth 1832-1854, University Park, Pennsylvania State University Press.
[53] Ibid.
[54] Ibid.
[55] Ibid.

Wishing to assert a new moral vision and a uniformity of rules on society, a new breed of municipal socialist emerged who chimed with the deepest instincts of the medical profession's conservatism.[56]

In the 1890s doctors began, in a repetition of past abuses of state power, to try to put the powers of the GMC to work in the service of their own pecuniary interests. As Green states:

> "The chief attraction of the General Medical Council was that it had the power to remove doctors from the medical register, which effectively meant to put them out of business. It could do so on two main grounds: (a) if they were guilty of a felony or a misdemeanour; or (b) if they were guilty of 'infamous conduct in any professional respect'. There was no appeal against its decisions."[57]

Section 29 of the 1858 Medical Act empowered the General Medical Council as follows:

> "If any registered medical practitioner...shall after due inquiry be judged by the General Medical Council to have been guilty of infamous conduct in any professional respect, the General Council may if they see fit direct the Registrar to erase the name of such medical practitioner from the Register."[58]

The power was tempered by section 52:

> "Provided always that nothing herein contained shall extend to authorise Her Majesty to create any new restriction in the practice of medicine or surgery, or to grant any of the said corporations any powers or privileges contrary to the common law of the land."[59]

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[56] John Burns, (1902) 'Municipal Socialism', London, The Clarion.
[57] David Green, op.cit., p. 36.
[58] Ibid.
[59] Ibid.

Given this, some doctors took the view that it constituted infamous conduct to fail to cooperate with professional restrictive practices intended to limit competition and raise fees. These doctors tried to use the General Medical Council to get other colleagues struck off the Medical Register for failing to engage in such restrictive trade practices. These moves began in earnest in 1892:

> "[An] approach to the GMC was led by the Medical Defence Union (MDU) and took the form of an attack on medical aid associations, a term which included commercial medical aid companies, as well as non-profit medical aid societies, provident dispensaries and friendly society medical institutes. The British Medical Journal supported the MDU, arguing that medical association doctors were 'practically' "sweated" for the profit of the associations. The BMJ wanted the GMC to declare employment by a medical aid association 'professionally degrading'."[60]

In their eagerness to find grounds which would permit the GMC to act the MDU tried to draw an analogy with an earlier GMC ruling on covering for unqualified persons:

> "The GMC had ruled that for a registered practitioner to act as the cover for an unqualified person in order that the unqualified individual could carry on medical practice as if he were qualified was 'infamous conduct in a professional respect', within the meaning of section 29 of the 1858 Act. The MDU argued that medical aid association doctors were covering in exactly the same way for the medical aid association committee."[61]

However, even the BMJ pointed out that there was a very clear distinction. The GMC's response was to appoint a committee which reported in June 1893.

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[60] Ibid., pp. 36-37.
[61] British Medical Journal, 15 October 1892, p. 854.

The criticisms of the MDU were answered by a doctor serving as the medical officer of a friendly society medical institute. He refuted the view that medical officers were 'sweated', and argued that on the contrary they had taken positions as medical officers to escape previous sweating practised on them by other doctors who had employed them as assistants.[62] He pointed out that all his colleagues had had to work harder for less pay as assistants to private practitioners than they did for medical institutes. Most had been given workloads at least twice as heavy when they were assistants, and some had carried burdens three times as great. He denied that friendly societies made profits from their work. If there was a surplus, it was reinvested to provide security of incomes in the future:

> "We are quite satisfied that our income should be thus secured, and we do not lay claim to this money."[63]

His view was supported by a doctor from South Wales who pointed out that that he received more pay from the 'Medical Aid' than he would have from the miners' club: the main local alternative which was based on pay-packet deductions.[64] Another medical officer of a medical aid association pointed out that if there was no association he would end up treating many of his patients under the Poor Law for much less.[65]

A conference of twenty-one friendly societies memorialised the General Medical Council in March 1893 emphasizing that friendly society medical institutes could not be described as organisations for the profit of their promoters and that they provided a service by mutual aid.

Simultaneously, a leading article in the Oddfellows Magazine pointed out that there was no objection to doctors' combinations which sought to enforce a minimum wage. But it was a very different matter to try to deny some doctors

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[62] David Green, op.cit., p. 37.
[63] British Medical Journal, 22 October 1892, p. 920.
[64] Ibid., p. 370
[65] British Medical Journal, 5 November 1892, p. 1028.

the choice of working for a medical aid association, or indeed to deny a doctor the right to work for whoever he pleased. Summing up the view of the friendly society movement, Green asserts:

> "The friendly societies felt that the attempt to use the power of the state (exercised by the GMC) represented an attempt to combine for improper ends. To try and raise wages by combination they believed to be legitimate; but to attempt to deny other doctors the right to work for the friendly societies was wholly illegitimate."[66]

Throughout the nineteenth century the labour movement, the friendly societies and the principles of mutuality and co-operation had become increasingly powerful. Crucially, they stood in opposition to the notion of public ownership being equated with state ownership. As Green has observed:

> "Victorian Britain tends to be thought of as the heyday of laissez-faire. In this view, welfare was the province of a restrictive Poor Law and burgeoning private charity; and the production of goods and services the province of profit-seeking commercial companies. But the Victorian age was not only the heyday of 'bourgeois' values. Existing alongside was a clear working-class alternative, aiming to replace the hated Poor Law and the largesse of the well-to-do with the mutual aid of the friendly society and the trade union branch."[67]

By striving to keep government control and elite politics out of people's lives, friendly societies, mutuals and co-operatives all – in their own ways - formed elements of a powerful, popular and broad based movement that promoted the idea of people owning, controlling and developing their own institutions for the delivery of health and welfare.

As the writer and journalist Stephen Pollard, a former research director of the Fabian Society, has pointed out:

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[66] David Green, op.cit., p. 38.
[67] Ibid., p. 1.

> "Against a great deal of modern mythology, the nineteenth century witnessed a variety of rapidly growing and highly successful institutions aimed at elevating citizens out of hardship. Friendly societies and savings banks played a key part in a broad movement which prided itself on providing individuals with efficient, effective and sustainable forms of welfare support."[68]

Nevertheless, a further attempt to use the power of the GMC was made in 1897 when Norwich doctors put forward a new proposal.[69] The same doctors also tried – unsuccessfully – to persuade the Royal College of Surgeons and the Royal College of Physicians to forbid their members from accepting positions in Friendly Society Medical Institutes (FSMI).

The Norwich FSMI has been established in 1872 and by 1897 had more than 10,000 members. There were two full-time salaried medical officers, a consulting physician and a consulting surgeon, though the consultants had just been successfully put under pressure to resign:

> "The complaint of the Norwich doctors was that the FSMI was a 'trading society conducted by laymen' for medical attendance. The annual subscription of 3s was not all passed on to the medical officers. Instead it was used to pay working expenses and to improve the premises."[70]

The response of the GMC was to appoint a committee which did not report until June 1899. The committee met with representatives of the friendly societies and concluded that Medical Institutes:

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[68] Stephen Pollard, Terry Liddle, Bill Thompson, (1994) Towards a More Co-operative Society: Ideas on the future of the British Labour Movement and Independent Healthcare, Independent Healthcare Association, London, p. 8.
[69] British Medical Journal, 24 July 1897, p. 238.
[70] David Green, op.cit., p. 42. Also see: GMC Minutes, 1897, pp. 201-2.

> "...composed of *bona fide* members of friendly societies, and managed on sound principles, are entitled to, and have always received, the friendly consideration of the medical profession."[71]

At this stage, the organised medical profession directed their most vehement criticism at the commercial medical aid companies, run mainly by the insurance companies. No doctor, it was felt by some colleagues, should be 'the stalking horse' of these companies. According to the BMJ it was:

> "...degrading to any medical man to allow his professional knowledge to be used by a commercial company as its stock-in-trade."[72]

Whilst on this, there was to be "no compromise", fair remuneration was a different matter. It was not a question of principle, but a matter in which a balance must be struck between the relevant parties.

Eventually, the committee of the GMC recommended that its parent body strongly disapprove of medical practitioners who associated with medical aid associations which systematically canvassed and advertised for purpose of procuring patients. The GMC unanimously resolved in favour of this resolution. However, this still fell short of ruling that employment by a medical aid society was 'infamous conduct'. The committee made it clear that this resolution only applied to companies canvassing and advertising to push insurance business intended to yield a profit.

Although the GMC's hostility to canvassing and advertising was confined to the use of such methods by commercial companies, many within the profession refused to apply any such limitation. Their intention was to stamp out all competition by force as the following resolution passed in July 1899 by the County of Durham Medical Union shows:

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[71] GMC, Minutes, 1898, pp. 91-2.
[72] David Green, op.cit., p.43.

> "That when the Qualified Practitioners of any district make a combined effort to raise the standard of their fees, and thereby the status of the profession, it should be deemed infamous conduct in a professional respect for any Registered Practitioner to attempt to frustrate their efforts by opposing them at cheaper rates of payment, and canvassing for patients..."[73]

The union explained to the GMC that they had been trying to raise contract medical fees in mining districts from 6d per fortnight to 9d. In some areas miners had refused the increase and established medical associations to employ doctors at a salary. These associations collected subscriptions and canvassed for patients. If it was not 'illegal', the union told the GMC, then they certainly thought it was 'scandalous'.

Many doctors clearly resented the GMC's refusal to intervene. One Rotherham doctor, who believed they always broke down through fear of outside doctors coming in, strongly criticized the General Medical Council. He argued that, as things stood, the GMC was 'absolutely useless' to general practitioners.[74]

Pressure on the GMC continued and in November 1901, in a major turning point, 'canvassing' was held to be infamous conduct. Then, a year later, came a second equally important decision. In 1902 a resolution declaring advertising to be 'infamous conduct' was finally resolved.

The landmark case concerned a doctor from Birmingham who had issued handbills in a poor district of Birmingham:

> "One circular had announced that he would provide a free service for the poor, and a second that he would make a token charge of 3d. This was issued because he had been inundated by the response to the first circular. He said in his defence that his aim had been purely charitable.

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[73] Ibid., p. 44. Also see: GMC Minutes, 1899, p. 275.
[74] Ibid.

> The Medical Defence Union, which had led the case against him, said that the circulars had been issued with one intention only: to take patients from other medical men. The GMC seem to have concurred and told him that they took 'a serious view' of his conduct."[75]

The decisions of 1901 and 1902 were the first occasions on which the power of the GMC had been openly used to further the pecuniary interests of doctors at the expense of patients.

The 1901 decision in particular, signalled the arrival of a new majority on the GMC; a majority willing to abuse the power of the state for sectional ends. As E. M. Little, the BMA's historian was to comment, the profession now found weapons:

> "...placed in its hands which it did not fail to use with effect".[76]

For Green, as the medical profession's effort to establish monopoly through local combinations failed, so it resorted to capturing the state through the GMC:

> "As their efforts to establish [local] monopolies failed, we found not only concerted efforts to combine in the marketplace, but also efforts being made to use the power of the state to make financial gains at the expense of consumers. The more extreme demands made by some sections of the profession were not acceded to, but the limitations on advertising and canvassing put considerable limits on competition. This abuse of the powers of the General Medical Council significantly increased the power of the profession at the expense of the consumer."[77]

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[75] Ibid., p. 46. Also see: British Medical Journal, 29 November 1902, pp. 1721-2.
[76] E. M. Little (1932) History of the British Medical Association 1832-1932, British Medical Association, London, p. 205.
[77] David Green, op.cit., p. 61.

For Green, the evidence of the period suggests that professional gains at the expense of the consumer tend to be greater, not in a free market, but:

> "...when the professionals have at their disposal the coercive power of the state."[78]

Mutuality and Co-operation in Healthcare

During the eighteenth and nineteenth centuries the labour movement viewed the notion of 'public ownership' as being oppositional to state ownership. Indeed, the labour movement became a powerful mass movement in the nineteenth century largely as a result of it aiding the material and conditional liberation of working people in such areas as health and welfare. By attempting to keep government control and elite politics out of people's lives, friendly societies, mutuals and co-operatives all promoted the means by which people could own, control and develop their own healthcare institutions. As Stephen Pollard has pointed out:

> "Against a great deal of modern mythology, the nineteenth century witnessed a variety of rapidly growing and highly successful institutions aimed at elevating citizens out of hardship. Friendly societies and savings banks played a key part in the broad movement which prided itself on providing individuals with efficient, effective and sustainable forms of welfare support."[79]

Asked in 1892 what proportion of the working classes were insured against sickness through a building society or through a trade union, the Chief Registrar of Friendly Societies answered that of 7 million male industrial workers, 3.86 million belonged to registered societies and another 3 million to unregistered societies.[80] At the end of the century, he wrote that:

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[78] Ibid., p. 62.
[79] Stephen Pollard, Terry Liddle, Bill Thompson, op.cit, p.8.
[80] P.H.J.H Gosden, (1973) Self-Help, Voluntary Associations in Nineteenth Century England, London, Longman, p.91.

> "...it remains one of the great glories of the Victorian era that...welfare has been established in a very large degree by the labours and sacrifices of working men themselves, and by the wise and judicious legislation which has permitted and encouraged their endeavour in the direction of self-help".[81]

By 1900 the total funds acquired by the various provident institutions amounted to nearly £400,000,000 and by the 1911 between nine and nine and a half million people were covered by various forms of insurance.[82]

By 1910 there were 6.6 million members of registered friendly societies, quite apart from those in the unregistered organisations. Significantly, their rate of growth over the preceding thirty years had been rapid and was accelerating.[83]

In 1877, registered membership had been 2.75 million. A decade later it was 3.6 million and increasing at an average of 90,000 a year. In 1897 membership had reached 4.8 million, having increased on average by 120,000 a year. And by 1910 the figures had reached 6.6 million, having increased at an average annual rate since 1897 of 140,000.[84]

Importantly, these were the figures known to the government which had imposed a regulatory framework of registration and 'protection' for the movement. But many societies preferred to avoid even the minimal interference of the 19th century British state and failed to register.

However, as the increasing success of non-state forms of welfare provision were accepted by large numbers of disparate groups who were happy to deal with such diverse institutions as private banks and trade unions, the question arises as to why this broadly based, populist movement went into decline?

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[81] Cited in P. H. J. H Gosden., (1973) Self Help: Voluntary Associations in Nineteenth Century Britain, B. T. Batsford Ltd, London, p.259
[82] Stephen Pollard, Terry Liddle, Bill Thompson, op.cit., pp.8-9.
[83] Ibid.
[84] Ibid.

This is an important question not least because the evidence suggests that so far as voluntary and co-operative health and welfare programmes went they were both trusted and liked by their clients. As Green notes:

> "Until the 1911 National Insurance Act every neighbourhood of every town was dotted with friendly society branches, each with their own doctor, who had usually been elected by a vote of all the members assembled in the branch meeting. In most large towns the friendly societies had also established medical institutes combining doctors' living accommodation, surgery and a dispensary. These embryo health centres employed full-time salaried medical practitioners, full-time dispensers, and nursing staff under the management of a committee elected by all members."

History also shows that the friendly societies were so successful that their arrangements for social insurance and primary medical care were used as the model for the early welfare state. However, this ironically was their undoing.

The 1911 National Insurance Act was initially seen by its instigator, Lloyd George, as a means of extending the benefits of the friendly societies to a wider population – and especially the poor. But the combination of the two most powerful interests – the organised medical profession and the commercial insurance companies (which together formed a powerful trade association known as the 'Combine') – mounted an extremely effective lobbying campaign and succeeded in transforming the shape of the Bill as it progressed through the House of Commons.

Outlining the campaign in this seminal work 'Working Class Patients and the Medical Establishment', David Green points out:

> "The BMA and the Combine formed a temporary alliance to extract concessions from the government at the expense of the friendly societies. The essence of working-class social insurance was democratic self-organisation; amendments to the Bill obtained by the

> BMA and the Combine undermined it. Doctors' pay had kept within the limits that ordinary manual workers could afford: under pressure, the government doubled doctors' incomes and financed this transfer of wealth from insured workers to the medical profession by means of a regressive poll tax, flat-rate National Insurance contributions."[85]

By the time of the Labour Party's formation in the early 1900s the British Socialist movement was a broadly based coalition containing many different shades of opinion: the utopians, the co-operatives, the friendly societies and the trade unions – all distrustful of a strong centralising state.

However, in line with a great deal of sociological thought at the time,[86] a new strand of Socialism began to emerge which argued for the establishment of new moral communities based on occupational membership. Bolstered by the earlier work of Chadwick, from the 1860s onwards a new generation of middle class, Fabian and Marxian Socialist began to influence the wider Labour movement, and pull it towards the ideas of a new welfare state.[87]

Indeed, towards the end of the Victorian era, British Socialism began to take on a more continental flavour and the Labour movement began to accept the ideas of state collectivism and the centralisation of power.

Arguably, the idea of non-state mutuality and co-operation in British healthcare was dealt its first major intellectual blow at the Socialist International of September 1872. For it was here that the two main proponents of nineteenth century socialism clashed.

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[85] David Green, (1985) Working Class Patients and the Medical Establishment, Gower/Maurice Temple Smith, Aldershot, op.cit p.2

[86] See: Stephen Pollard, Terry Liddle, Bill Thompson, op.cit., p.10.

[87] Indeed, at the time there was an alliance between statist Toryism and statist Socialism. See: Semmel, B., (1960) Imperialism and Social Reform: English Social-Imperial Thought 1895-1914, Cambridge MA, Harvard University Press. On the foundations of the welfare state also see Searle, G. R., (1971) The Quest for National Efficiency, Oxford, Oxford University Press and (1986) Social Hygiene in Twenthieth Century Britain, London, Croom Helm; Skocpol, T., (1992) Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States, Cambridge MA, Belknap Press/Harvard University Press.

On one side was the anti-state individualist tradition represented by Michael Bakunin and on the other the statist stream lead by Karl Marx.[88]

Although Bakunin's side formally lost the debate, it is interesting to remember his prophetic words against a socialism built upon a monopoly state. In 1868 he warned:

> "...Equality without freedom is the despotism of the State. ...the most fatal combination that could possibly be formed, would be to unite socialism to absolutism; to unite the aspiration of the people for material well-being...with the dictatorship or the concentration of all political and social power in the State....We must seek full economic and social justice only by way of freedom. There can be nothing living or human outside of liberty, and a socialism that does not accept freedom as its only creative principle...will inevitably...lead to slavery and brutality".[89]

At the end of the nineteenth century, and in addition to Marx, Europe saw another powerful statist emerge who was to have a profound impact on British political thinking and who greatly encouraged the establishment of a top-down welfare state.

Count Otto von Bismark was brought to power through the demands of military spending. In 1862, Wilhelm I of Prussia was on the verge of abdication after the demand that to approve his increase of taxation he would have to accept parliamentary control of the executive. As a final move, Wilhelm recalled Bismarck from being ambassador to France and appointed him as Minister President – the equivalent of Prime Minister.[90]

Bismarck's policy for Germany was clear. Increase the army from 500,000 to 750,000. Extend conscription from two to four years. And increase taxation to

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[88] Sam Dolgoff, (1973) Bakunin on Anarchy, Greorge Allen and Unwin.
[89] Ibid., p.4
[90] Paul Marks (1992) Bismarck: The Harm Done by one Individual to the Cause of Individualism, Historical Notes No.19, London, Libertarian Alliance.

cover the costs, without conceding any power to the taxpayers in exchange.[91] The liberals talked of revolt but failed to match their words with actions - and Bismarck called their bluff.

From entering office, Bismarck purged the liberals in the Prussian civil service and censored the press. After 1866, he used large sums stolen from the blind King of Hanover to bribe journalists and others to support him.[92]

Bismarck undermined the liberal agenda in other ways. Firstly, he helped to split them between the 'progressives' and the 'National Liberals' who supported his policy of war mongering. Secondly, he secretly subsidised state Socialists such as Ferdinand Lassalle[93] to win workers away from the liberals, to support the state.

In 1879 Bismarck took advantage of severe economic problems to break the power of the National Liberals who had supported him. In 1884, he moved the state forward again and introduced compulsory sickness 'insurance' (compulsory contributions from employers and employees), accident 'insurance' (from employers only) and in 1899 old age pensions (with contributions from employers, employees and general taxation).[94]

These schemes grew rapidly and 'progressive' income tax arrived in 1891. By helping to spread the belief that 'capital' and 'labour' had different interests, by stirring up 'the masses' against industrialists and making industrialists fear 'the masses', and by making both sides look to the state, Bismarck set the scene for the destruction of traditional liberties, freedoms and the self help movement.

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[91] Ibid., p.2.
[92] Ibid., p.3.
[93] As Nietche and others knew, the official anti-socialist stance of the state was a fraud. Liberalism was the true enemy of the state as taken to its final conclusions it would ultimately erode the state itself. See Nietzche's 'A Glance at the State' in his Human All Too Human, 1878 pp.472-473.
[94] Paul Marks, op.cit., p.3.

Over time, his policies had a huge impact not only on the political class of Germany but many other European countries.[95] In Britain, the early welfare state followed an essentially Bismarkian model and began with the 1911 National Insurance Act.

It provided a safety net against both sickness and unemployment, and, with some important exceptions, covered all those between the ages of 16 and 70 who were manual workers, earned less than £160 per year or worked in industries "known to be subject to severe and recurrent unemployment".[96] The scheme was funded by weekly contributions from the insured worker, from the employer and from the Government. The basic weekly sickness benefit was 10s for men and 7s 6d for women. In addition to direct payments, the Act also provided for the setting up of general medical and pharmaceutical services.

In addition to enhancing the power of the medical establishment, as stated above, the 1911 Act introduced a compulsory insurance system which undermined the working class self help movement. Workers no longer needed to arrange their own affairs as best they could: the state would do that for them.

While the 1911 Act agreed to administer the new system through friendly societies, it did so only through those that had been 'approved'. However, to be approved, a society was required to have at least 10,000 members, and to conduct its business under far closer state supervision than ever before.[97]

The result was that the sickness and unemployment insurance of the working classes was effectively monopolised by the state, which had handed the business to a few favoured societies – increasingly virtual government agencies. Not surprisingly, thousands of small and unregistered societies soon found themselves left searching for what little business remained and most inevitably died.

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[95] Ibid.
[96] Stephen Pollard, Terry Liddle, Bill Thompson, op.cit., p.10.
[97] Ibid.

The inside story of how this came about was eventually told by W.J. Braithwaite, who was one of the officials connected with the National Insurance Bill:

> "The reception of the bill had been very friendly. There had, however, been one discordant note from ... the spokesman in the House [of Commons] of the Industrial Insurance interest, far the most formidable interest affected by the bill. Interests are a very real force in Parliament. They are alive and active. The public interest which should come before them is inert and dead compared with them, and had no spokesman or representative... The history of the bill is how they were bought off, conciliated, and in very few instances over-ruled. L[loyd] G[eorge] made promise after promise, did one doge after another...
>
> "...The Industrial storm had already blown up. It was very cleverly worked, and I suppose that Kingsley Wood [legal adviser to the insurance interests] was at the bottom of it. At any rate he said to me one day when the storm was in full blast. 'We have got L.G. there' (putting this thumb on the desk) ' and shall get our own terms'".[98]

The health and welfare legislation of the 1940s can arguably be seen as a logical extension of ideas first floated at the first international in 1872 and in Bismark's Germany during the 1880s. Sparked in Britain by the National Insurance Act of 1911 and hugely advanced by the crises of the Great War, the subsequent inter-war slump, and finally the Second World War, it ended with legislation from a Labour Government as far divorced as can be imagined from the ideals of the labour movement's historic roots and from crucial market sensivities.

In many ways policy developments of the late 1940s and the arrival of the NHS were simply a logical next-step of the ideas and interests of the previous and increasingly statist decades.

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[98] Sir Henry N. Bunbury (ed) Lloyd George's Ambulance Wagon, The Memoirs of William J. Braithwaite, Methuen Ltd, London 1957, pp.161-168.

British hospitals before the NHS

To further highlight the gathering statism of the age one can examine the history and experience of the British voluntary hospital movement during the latter stages of the nineteenth century, up to the early 1940s.

By the turn of the twentieth century the term voluntary hospital denoted three key features. Income was not drawn from the public purse but from philanthropy. Management was in the hands of a voluntary governing body which was accountable only to the subscribers, and medical care was primarily provided by honorary consultants who were not paid by the hospital.[99]

In the first half of the nineteenth century, general hospitals opened in most large towns, while specialist institutions covering such areas as ophthalmology, maternity and ear, nose and throat, also emerged. The latter stages of the century saw this trend continue, along with the arrival of the rurally based cottage hospital movement.[100] From early on, medical education was a feature of the largest voluntary hospitals, with honorary consultants supplementing their income by apprenticeship fees for clinical teaching.[101] Links with medical schools were subsequently formalised. By the early 20th century, the transition of hospitals from primarily philanthropic to primarily medical institutions was apparent.[102]

The 31 teaching hospitals were centres of medical research and scientific progress. Honorary staff held positions in local university medical schools, and

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[99] British Hospitals Association (BHA), Report of the Voluntary Hospitals Commission (London, 1937); Political and Economic Planning (PEP) Report on the British health services (London, 1937), pp. 16-17, 230-240; J. E Stone, Hospital Organisation and management (London, 1927), p.12. Importantly, the first wave of voluntary foundations in London and the provincial cities took place during the 18th century, when the popularity of subscriber charity superseded the philanthropic trend of the endowed trust. The rhetoric of early hospital appeals suggests donors' motives could range from a sense of religious duty to a desire for moral reform.

[100] S. Cherry, 'Change and continuity in the cottage hospitals c. 1859-1948', Medical History, (1992), pps.36, 271-89.

[101] M. E. Fissell, (1991) Patients, power and poor in eighteenth century Bristol, Chapter 7; B. Abel-Smith, (1964) The Hospitals 1800-1948, London, pp. 16-31.

[102] K. Waddington (2000) Charity and the London Hospitals 1850-1898, Woodbridge.

the introduction of bacteriology and pathology laboratories started to shift both clinical training and diagnostic practice from bedside to bench.[103] Not all hospital beds were in the voluntary sector. Indeed, in the run up to 1948, they remained a minority, increasingly overshadowed by publicly funded provision.

The Poor Law had of course historically performed a medical role, wherein Victorian workhouses accommodated the sick alongside the aged, the 'lunatic' and the 'destitute'. By the early 20th century only 20 per cent of Poor Law beds were in separate infirmaries.[104] Importantly, the standard of care they provided was generally inferior to that available in the voluntary sector. Staff to patient ratios were worse and the practice of delegating nursing care to untrained pauper inmates was slow to change.[105] Moreover, in line with the creeping intellectual statism of the age, local authorities had since 1867 built publicly funded hospitals to address infectious diseases - in particular, isolation hospitals for scarlet fever, diphtheria and tuberculosis.

In 1929 public provision was again expanded and restructured. This time the Local Government Act broke up the Poor Law and brought its institutions under the purview of local authorities. This Act also forced councils to open municipal general hospitals, whose ambit included the non-pauperised acute and maternity patients who hitherto had been treated in the voluntary sector.[106] Precise estimates of the sectorial shares of beds are hard to asses. However, Pinker's analysis of sporadic official records provides an overview for the period 1891 and 1938.[107]

The gathering dominance of the public sector is evident, with an ever-increasing proportion of beds located in the local authority hospitals; particularly by 1938 when the Local Government Act had begun to take effect.

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[103] S. Sturdy and R. Cooter, 'Science, scientific management and the transformation of medicine in Britain 1870-1950', History of Science (1998), xxxvi, pp.421-66.
[104] M. A. Crowther (1981) The Workhouse System 1834-1929, London, p. 186.
[105] A. Digby, (1978) Pauper Palaces, London, pp. 171-2. Also see M. A. Crowther, ibid., pp. 162-6, 182-90.
[106] M. Powell (1964) 'An Expanding Service: Municipal Acute Medicine in the 1930s', in Twentieth Century British History (1997) pps., 8, 334-57.
[107] R. Pinker, (1966) English Hospital Statistics 1861-1938, London, pp. 61-2.

It is also clear that the inter-war period was a time of considerable expansion for the voluntary units, whose share of total bed numbers had increased (see Figure 1).

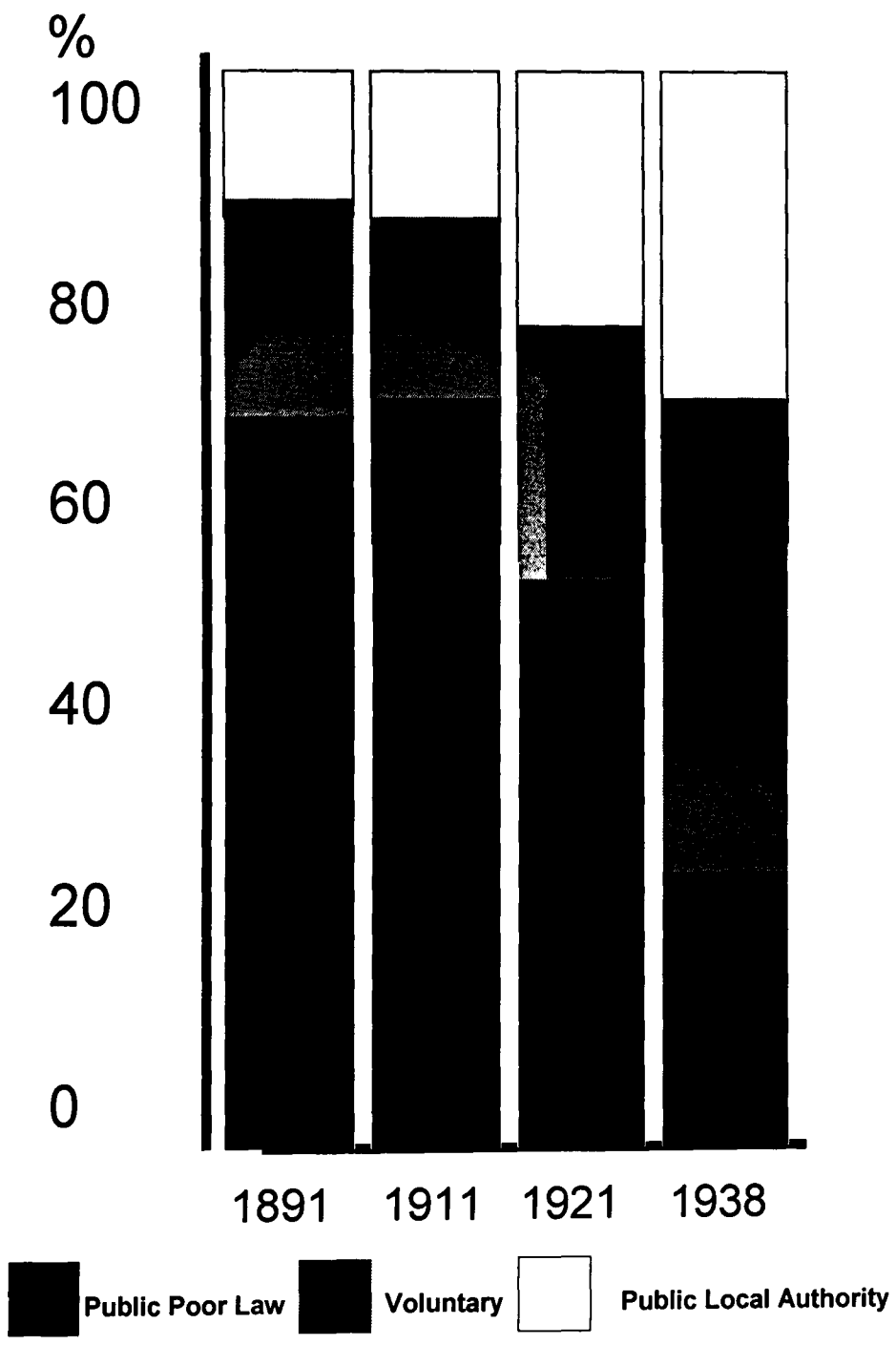

Figure 1. The distribution of hospital beds in the public and voluntary sectors, England and Wales 1891-1938

Given the expansion in bed numbers, it is not surprising that income also grew impressively between 1900 and 1938.

The total annual income of British voluntary hospitals in 1901 was £2.1 million, rising to £15.4 million by 1938. Or, if adjusted to take account of price changes: £6 million rising to £27 million, at 1948 prices.[108]

In London, where about one quarter of the nation's hospital beds were located, annual income grew from £2.6 million in 1921 to £4.7 million in 1938 – or £3 million to £8 million at 1948 prices.[109]

This was by no means an easy process, and in the immediate years after the First World War many came to believe that state funding would have to supersede voluntary sources if the hospitals were going to survive. Financial pressures were at their greatest when a conjuncture of forces impacted on the hospitals. Philanthropy was undermined not least because the better off were now liable for unprecedented levels of income taxation including death duties. Post-war inflation also took its toll, pushing up the price of fuel and provisions. Moreover, essential building and maintenance work had been postponed during the war and now had to be addressed. Finally, and to compound all these pressures, the influenza pandemic placed additional – unprecedented – pressures on staff and resources.[110]

In response to this situation, the government established in 1921 the Cave Committee to report on the hospitals' plight and to recommend solutions. The result was a Treasury grant of £500,000, dependent on matching funding being obtained from voluntary sources.[111] This was duly found and allocated and by the mid-1920s the crisis had passed: the voluntary system had been partially preserved.

However, the First World War was a turning point and the subsequent growth in income was sustained by a changed mix of funding sources.

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[108] John Mohan and Martin Gorsky (2001) Don't Look Back? Voluntary and Charitable Finance of Hospitals in Britain, Past and Present, Office of Health Economics, London, p. 40.
[109] Ibid.
[110] B. Abel-Smith, op.cit, pp. 307-9, 232-4.
[111] J. E. Stone (1927) Hospital Organisation and Management, London, pp.45-8.

Figure 2. illustrates the composition of annual income in British voluntary hospitals, based on the returns of current data reported in three series of hospital year-books.[112]

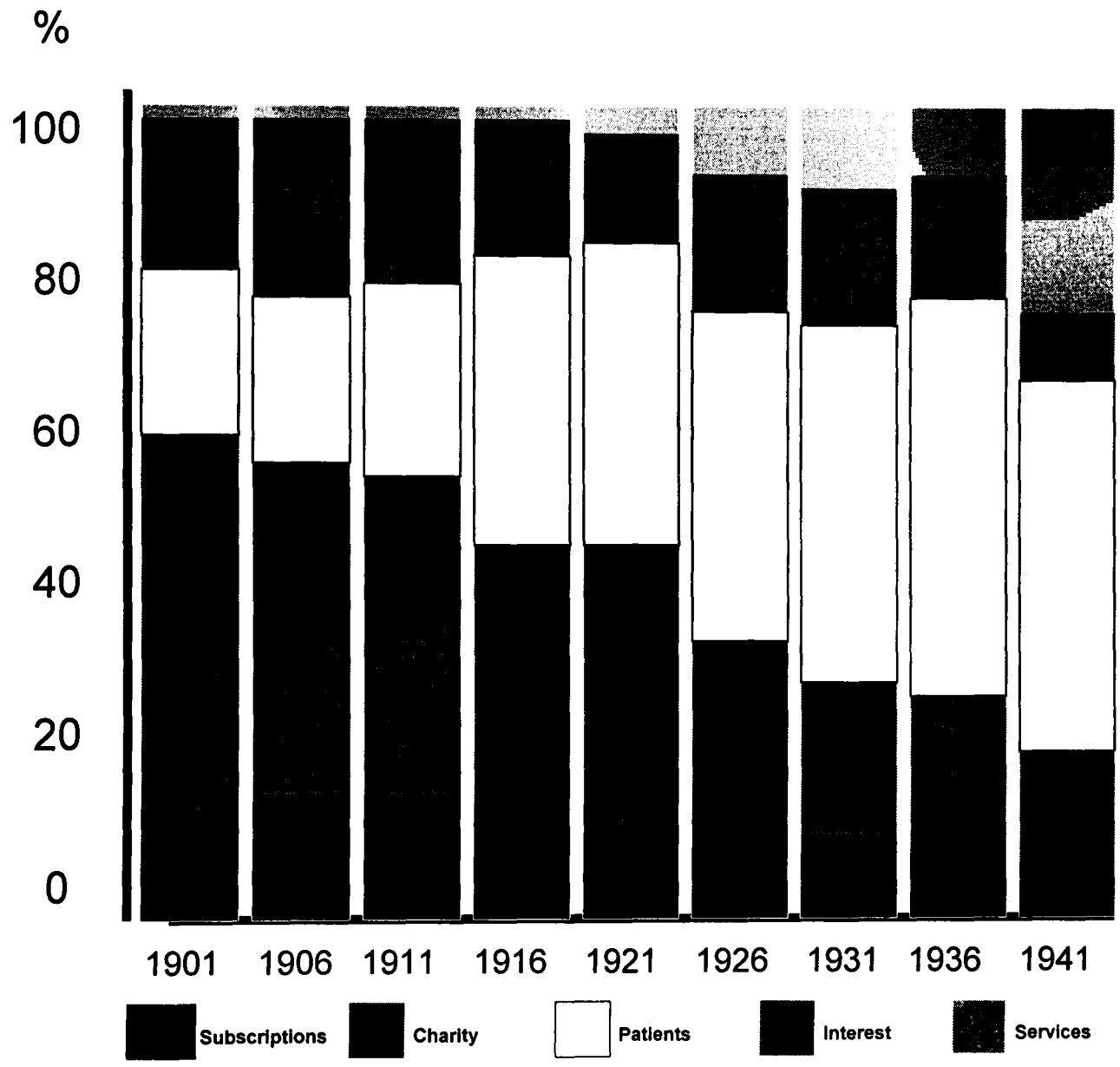

Figure 2. Composition of voluntary hospital incomes England, Scotland and Wales, 1901-1941.

London is not included in this illustration since after 1923 the capital's statistics were drawn from the King's Fund abstracts which did not disaggregate charitable income to the same level of detail.

The categories of 'subscription' (an annual pledged sum) and 'charity' (donations, legacies, church collections, fund-raising events) had been the original mainstay of income. However, they underwent a long-run decline, first clearly noticeable at the time of the 1914-18 war, and broken only with a brief

[112] These are Burdett's Hospitals and Charities, the Hospitals Yearbook and the Order of St. John's Annual Reports on the Voluntary Hospitals of Great Britain.

resurgence in the early 1920s when renewed philanthropic benevolence was crucial in overcoming the post-war crisis.

The category of 'patients', which after 1914 bulked ever larger, is composed of both direct payment by patients and income from mass contributory schemes. Direct payment took the form either of a charge made on the better off patients for the cost of hospitalisation, or of a sum levied by the hospital almoner according to the patient's capacity.

The contributory schemes had developed from workplace funds supported by small subscriptions, but flourished from the 1920s when they were promoted by the hospitals themselves in a bid to broaden their base of support during the funding crisis of 1918-21.

'Interest' refers to annual yields on assets, mostly gilts and equities, but sometimes property too; this remained a stable proportion of total income.

'Services' includes income earned from home nursing and fees paid by local and national government. Growth in this category after 1921 represents the local authority subventions mentioned above, and the increase in 1941 reflects the state payments made under the wartime Emergency Medical Service.

During the 1920s and 1930s, while charity had not actually gone into decline, it clearly failed to expand at the rate required to meet expenditure demands. In the provinces income from patients far surpassed that of charity, and was the key to the growth of the system.

In London it also grew significantly over the period, but here charitable finance, though broadly static, remained the dominant factor. This was despite the fact that the country's largest contributory scheme, the Hospital Saving Association (HSA), was based in the capital.

Started in 1923 with a grant from the King's Fund, the HSA gathered regular contributions of 3d per week from families on 'limited incomes', which guaranteed them exemption from charges or means-testing for hospital treatment. However, its impact was dissipated amongst the large number of institutions in London. Traditional modes of charity were also more robust, with fund-raising activities remaining a vital part of the social round of the metropolitan elite.[113]

However, throughout the 1920s and 1930s new forms of infrastructure demanded considerable capital expenditure. In addition to new wards, this included the equipping of specialist departments and laboratories, X-ray and radiology appliances, as well as telephone systems, electrification, lifts and steam laundries.[114]

Another, more significant, long-run trend was the rising share of the budget spent on staffing – which by 1941 accounted for 48 per cent of main expenditure.

This increase is not simply accounted for by the greater cost of salaried doctors, although by this time it had become common place for even the smaller hospitals to employ medical residents. The more important factor was the improved pay and conditions for nurses and ancillary workers. With higher wages, pensions and shorter hours, expenditure rose dramatically.[115] Even though nurses' pay and conditions remained less attractive than in other white blouse occupations, their growing professional assertiveness, coupled with and a tight labour market and rising salaries in the public hospitals, won them a larger share of the staff budget.

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[113] M. Gorsky and J. Mohan, 'London's Voluntary Hospitals in the Inter-War Period: Growth, Transformation or Crisis?', Non-profit and Voluntary Sector Quarterly, 2001

[114] John Mohan and Martin Gorsky (2001) Don't Look Back? Voluntary and Charitable Finance of Hospitals in Britain, Past and Present, Office of Health Economics, London, pp. 44-46.

[115] Ibid, p. 46.

Additional pressure was applied by the advance of specialist treatments, ranging from orthopaedic clinics to radiology departments which required a higher degree of training and hence remuneration.

Overall, consideration of Britain's voluntary hospitals during this time reveals a broad trend of growing financial hardship throughout the 1930s. As John Mohan and Martin Gorsky have recently concluded:

> "After rising during 1929-32, the years of economic slump, the proportion of hospitals in deficit fell until the mid-1930s, before rising again up to 1939, at which point more than one third of all the hospitals in the set reported deficits. The situation was eased only with the onset of the wartime emergency scheme, when state support brought the proportion in deficit down to a lower level than at any time since 1929."[116]

In 1938 the British Hospitals Association (BHA), the voluntary sector's mouthpiece, noted that:

> "...the position of hospitals with persistent annual deficits (was) one of particular urgency."[117]

A "deteriorating financial base"[118] in the late 1930s means that in overall terms:

> "...the inter-war period saw growth, transition and persistent difficulties in the financing of voluntary hospitals. Costs were driven up by the massive expansion in provision, the burgeoning staffing budget, the modernisation of the institutional fabric and the need to exploit new medical technologies. Traditional modes of hierarchical charity were

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[116] Ibid, p. 48.
[117] British Hospitals Association, (1937) Report of the Voluntary Hospitals Commission, London, p. 27.
[118] See: John Mohan and Martin Gorsky (2001) Don't Look Back? Voluntary and Charitable Finance of Hospitals in Britain, Past and Present, Office of Health Economics, London, p. 49.

> insufficient to sustain these demands. Personal taxation had risen to unprecedented levels, while the emergence of tax-funded municipal general hospitals after 1929 further undermined the philanthropic impulses; this in turn eroded the asset base. Survival therefore depended on a creative and flexible response by voluntary fund-raisers. This took the form of a new reliance on private payment and a shift to mass contributory arrangements; whose success was founded upon the local loyalties which voluntary hospitals inspired. However, the late 1930s saw financial crisis looming, as current account deficits multiplied and some institutions sank seriously into debt. For many hospitals the problems of reconciling charitable insufficiency with public expectation proved too great, and were resolved only by government aid in the wartime emergency."[119]

On the eve of World War II the voluntary sector provided 95,000 non-psychiatric hospital beds in England and Wales, out of a total – including local authority and Poor Law hospitals of 295,000 beds.[120]

Though the public sector was clearly dominant, this reflected its significance in providing long-stay hospitals and isolation facilities. Voluntary hospitals provided a majority of general hospital beds - 70,000, compared to 60,000 beds in local authority hospitals.[121]

When it comes to pre-war waiting lists the picture is sketchier. Not only was no such data available nationally prior to the Hospital Surveys but such information should not be used un-critically.

Although many hospitals often proved to be immensely popular they had not always been founded in response to a pre-existing articulation of popular demand for institutional care. Instead, the desire for hospitals (what

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[119] Ibid, pp.52-3.
[120] Ibid, p.60.
[121] Ibid.

contemporaries called the 'hospital habit') often followed the arrival and spread of the institution.

By the early 20th century normative expectations of hospital provision had decisively shifted, reflecting public appreciation of the more specialised skills of physicians and surgeons, the importance of easy access in accident and emergency cases, and of the technological facilities offered; such as X-ray machines, operating theatres and in the 1930s radium treatment for cancer.

In addition, need for hospital care, then as now, varied from place to place according to factors such as the occupational and age structure of the population.

These in turn necessitate different responses from hospitals: a greater preponderance of geriatric beds in one place, more resources devoted to maternity care in another.

However, hospital establishment depended largely on the motivations of local elites: doctors, church-leaders, businessmen and professionals with an interest in civic affairs. This market was not driven by the profit motive but the view that voluntary altruism was the way forward. As such, Voluntary:

> "Foundations were typically the initiative of wealthy citizens, perhaps eager to emulate the institutional glories of other cities, or animated by personal or family experience of ill health and recovery which prompted direct benevolence to a hospital. The first step was the constitution of a trustee body and the organisation of an initial round of subscription and donation to raise funds for the building. Alternatively, this might be led by medical men arguing that the prevalence of disease necessitated such intervention.[122]

[122] John Mohan and Martin Gorsky (2001) Don't Look Back? Voluntary and Charitable Finance of Hospitals in Britain, Past and Present, Office of Health Economics, London, p.54.

In some locations the concern of industrialists to protect their labour force was the key issue. In other places the tenor of local politics could play a part, either when factions of party and sect used philanthropy to advance their own position, or when joint philanthropic projects were initiated to promote civic unity over factionalism.[123]

Disparities in provision had first raised alarm bells in London when, during the 1860s, the public had expressed a concern that hospital accommodation was concentrated in the centre and West End of the city.

In 1902 the King's Fund, which had been established as a central agency to rationalise voluntary fund-raising in the capital, began to target its gifts so as to provide incentives for relocation to these areas.[124]

Despite this, the persistence in the 1930s of substantial variations in provision was used by the London County Council to justify its policy of opening rate-funded municipal general hospitals to deliver acute care.

By the late-1930s and early 1940s the notion that regional diversity was a weakness of voluntarism to be addressed by state planning and interventionism had gained broad acceptance, as evidenced by the influential 'PEP' Report on the British Health Services and by wartime hospital surveys carried out by the Ministry of Health.[125]

When presenting the NHS Bill to the House of Commons Aneurin Bevan noted that owing to the "caprice of charity" the best endowed areas were those:

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[123] A. Wilson 'Conflict, consensus and charity: politics and the provincial voluntary hospitals in the eighteenth century', English Historical Review, cxi, 599-619.

[124] G. Rivett, (1986) The Development of the London Hospital System 1823-1982, London, pp. 94-102, 124-5, 134, 161-70. Also see: F, Prochaska (1992) Philanthropy and the Hospitals of London, Oxford, pp. 66-70.

[125] PEP, op.cit, pp. 256-62.

> "Where the well-to-do live while, in very many other of our industrial and rural districts there is inadequate hospital accommodation."[126]

Although the Second World War was a significant contributory factor to the creation of the National Health Service, there seemed to be an inexorable, inevitable, passage towards the welfare state and the full blown nationalisation of health care.

Now, another half a century on and historians are increasingly looking back to the late eighteenth century when the voluntary hospitals first emerged in 'civil society'. That is, a 'public sphere' which developed autonomously from the activities and organisations of the state and the market. Today, the popular perception is that:

> "Its key feature was the efflorescence of charitable, educational and cultural institutions which rapidly became a ubiquitous feature of urban living. Unlike the closed vestries and corporations of unreformed Britain their membership was open to all, and principles of transparency and accountability were fundamental to their procedures."[127]

In many ways the voluntary hospital movement epitomised many of the aspects of this new associtionalism, and as such may be seen as a beacon of citizen participation. Public accountability was ensured through printed annual reports, which contained audited accounts, patient statistics, current rules and even the names and contribution of each subscriber, and all of which was available to the local press.

Payment of an annual subscription entitled donors to exercise various managerial prerogatives. These included the right to admit patients and to vote at general meetings held a least once a year.

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[126] HC Deb., 5th Series, v. 422, c. 46-7.
[127] John Mohan and Martin Gorsky (2001) Don't Look Back? Voluntary and Charitable Finance of Hospitals in Britain, Past and Present, Office of Health Economics, London, p. 79.

In the nineteenth century the subscribers' franchise could also extend to the election of the medical staff, obliging doctors seeking honorary posts to canvass publicly on behalf of their candidates. Subscribers also elected from amongst their number the volunteer members of the hospital, and the hospital 'visitors' who offered pastoral care to patients.

By the early twentieth century the administrative role of the voluntary subscriber was significantly reduced. Middle-class enthusiasm for involvement in local hospital affairs did not grow at the same rate as the burgeoning middle class. As the public sector grew so an increasingly significant free rider effect became apparent in the voluntary sector. Many citizens who could afford to subscribe to the voluntary sector decided not to and instead chose to allow their more public spirited neighbours to shoulder the increasing burden.

In Bristol in 1931 for example the number of private subscribers to the two main voluntary hospitals stood at 6,000. At the time, the city had a population of more than 400,000 people. [128]

Similarly, Newcastle's Royal Victoria Infirmary had only 400 charitable subscribers although it inhabited an area populated by more than one million people.[129]

As the formal involvement of lay volunteers and subscribers waned so the power of the medical men was waxing. Alongside the capture of ever greater political power, doctors were now able to take advantage of the new age of expanding hospital accommodation. For one thing, this gave them discretion to admit non-emergency patients without a subscriber's letter.

In many hospitals the balance tilted rapidly from predominantly charitable to predominantly medical admissions. This process was hastened by the growing assertiveness of honorary medical staff who, though motivated by

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[128] Ibid., p. 80.
[129] Ibid.

goodwill, also viewed the hospital as a place of research, teaching and scientific expertise.

> "Direct election of consultants was abandoned by the late nineteenth century in favour of selection by an appointments committee. In large hospitals medical committees were constituted to act as a forum for the development of the medical policy and to articulate doctors' needs to the lay governors. Thus despite some notorious clashes between medical representatives and voluntary administrators...the managerial role of doctors was generally enhanced."[130]

Although the decline of subscriber power did not entirely inhibit lay voluntary control, the growth of workplace contributions did manage to broaden public participation somewhat.

In financial terms the dwindling of private subscription was amply compensated by the sums which mass contributory schemes generated. Although these schemes had been greatly undermined by the 1911 National Insurance Act, the inter-war period did witness a brief re-emergence not least for the larger health plans.

The Cave Committee report of 1921 – which examined hospital finance – had advocated mass contribution as a solution to post-war funding shortfalls and many hospitals independently established their own local schemes so as to ease financial pressures.

Some hospitals regarded this form of income as a quasi-charitable voluntary gift, while others treated it as a form of low-cost insurance, with payment formally entitling those covered to remission of charges.

The upshot was that in some areas the numbers of voluntary hospital contributors increased:

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[130] Ibid., p. 81.

> "In Newcastle's Royal Victoria Infirmary for instance, over 50,000 belonged to the scheme in 1938, providing 58% of total income."[131]

To some extent this expansion of contribution reinvigorated a degree of popular participation in hospital affairs. The constitution of management committees was gradually changed to accommodate representatives of the schemes, though even in hospitals where mass contribution was a vital income source the numbers of such representatives remained a minority.

Continuing with the example of Newcastle and the Royal Victoria Infirmary's 44 committee members in 1901, only 12 were nominated by the workmen governors, and this minority persisted into the inter-war period. Despite this, there is little doubt that contribution strengthened ties of loyalty and support from workers for their hospital. In many cases this took the form of the purchase of essential equipment, the endowment of a bed, the organisation of fund-raising activities and gifts 'in kind', such as clothes made by sewing clubs.

In summary, although there were elements of openness, subscriber democracy and accountability in voluntary hospitals since their inception, participation was initially limited to middle-class contributors. The role of private subscribers subsequently diminished and the decision-making roles of medical professionals and lay governing bodies were enhanced.

The transition to mass contribution schemes briefly strengthened popular support for the institutions. However, management remained in the hands of traditional elites who were reluctant to adopt constitutions that either opened the hospitals up to market forces and 'profit' or further enhanced local democratic participation.

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[131] Voluntary Hospitals Committee (Chairman: Lord Cave), Final Report, 1921, Command 1335, p. 19.

Indeed, the prejudice and conservatism of the age was summed up by Bevan's experience, as asserted in the second reading of the NHS Bill:

> "In the mining districts, in the textile districts, in the districts where there are heavy industries it is the industrial population who pay the weekly contributions....When I was a miner I used to find that situation when I was on the hospital committee. We had an annual meeting and a cordial vote of thanks was passed to the manager of the colliery company for his generosity towards the hospital; and when I looked at the balance sheet I saw that 97.5% of the revenues were provided by the miners' own contributions; but nobody passed a vote of thanks to the miners."[132]

Throughout the 1920s, 1930s and 1940s the emerging consensus amongst opinion formers, medical professionals and politicians was in favour of greater centralised planning and 'co-ordination' of health services.

During the inter-war period, the popular challenge for policy makers and hospital managers was to secure, what they believed would be, the benefits of an integrated system through a partnership of public and non-profit providers.

In line with the increasingly statist thinking of previous decades the Nuffield Hospital Surveys stated in 1946 that "there is no hospital system now" and condemned "the results of uncoordinated development in the past".[133]

Looking back, it is now clear that the 1920s began with a clear belief in a more 'coherent' – governmentally – planned health system built around joint committees representing voluntary hospital leaders and public officials. As such, the benefits envisaged were cost savings through joint purchasing, co-ordination of fund-raising, the elimination of competition and therefore the

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[132] HC Debs, 5th Series, v. 422, c. 47.
[133] Nuffield Provincial Hospitals Trust, (1946) The Hospital Surveys: The Domesday Book of the Hospital Services, Oxford, p.4.

duplication of services, a planned provision of accommodation, and improvement of research and teaching.

At the same time the newly formed Ministry of Health[134] advocated closer links between amalgamated groups of voluntary hospitals and university medical schools, whose full-time staff would take over clinical teaching.

The Local Government Act of 1929 embodied a more determined attempt to promote Statism and top-down planning. Section 13 of the Act provided for the establishment of joint public/voluntary committees which would organise the respective contributions of the two sectors.

Importantly, six years after the 1929 Act's inception, the Ministry of Health surveyed the progress of this measure and discovered that while joint committees had been established in 43 out of 78 English boroughs, 23 had made no formal arrangements and 12 had taken no action at all.

In many places the gulf of interest and ideology between the municipal socialist and the voluntary hospital movements was simply too great. In London for example, where formal arrangements had been rapidly put in place:

> "...the antipathy between municipal socialists on the London County Council and aristocratic voluntary hospital patrons had fostered a state of 'cold war' in which genuine co-operation remained limited."[135]

Importantly, where a degree of system integration did emerge in the 1930s it was usually as a result of the broadening coverage of the mass contributory schemes.

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[134] The Ministry of Health had only been formed in 1919.

[135] John Mohan and Martin Gorsky (2001) Don't Look Back? Voluntary and Charitable Finance of Hospitals in Britain, Past and Present, Office of Health Economics, London, p. 87. Also see: J. Pater (1982) The Making of the NHS, London, p.16; Rivett, op.cit., pp. 205-6; Prochaska, op.cit., p. 114.

The principle of restricting treatment of contributors to a single local hospital proved to be inadequate in the age of the motor car and ever better communications. Mutual agreements to treat members of other schemes were therefore soon established between public and voluntary hospitals, and between large and small voluntaries in response to market demand.[136] This in turn created pressure for more product integration from one place to another – and encouraged a world of emerging, uniform and trusted health brands.

However, they were never as successful as they could have been. For in reality the momentum towards full blown Nationalisation had already been established both intellectually and institutionally.

By the early 1940s the context in which nationalisation would occur had become compelling and seemingly inevitable. After all, healthcare had never been provided by an unfettered market – even in ancient times.

Since Roman times, political elites in Britain have increasingly sought to plan, control and regulate the provision of health services. Through the military, the church, the Royal Colleges, Parliament, and the granting of professional legislative favour in the name of the 'public good', the state has progressively encroached on every area and facet of healthcare. Today, there are even those who argue that the political elite are seeking to undermine the traditional relationship of the doctor and the patient by eroding patient privacy and therefore the Hippocratic Oath.[137]

It is in this broader historic context that the establishment of a National Health Service can be seen to be more than simply the product of any single government - or party political tribe.

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[136] J. Mohan and M. Gorsky, Ibid., pp. 88-89.

[137] Tim Evans and Helen Evans (2001) Big Mother's Deadly New World: How the Government is Going to Destroy Patient's Health Records and Kill People, Legal Notes No.36, London, Libertarian Alliance.

Instead, it can be viewed as the historic culmination of deeply rooted intellectual and institutional prejudices which have gathered momentum and influence over long periods of time.

In the modern world, the political control of healthcare is invariably legitimated by egalitarian notions of 'public service', 'public ownership' and 'equality'.

Today, more than half a century on from the inception of the NHS, one is able to examine its record and judge it against its own legitimating rubrics. One can examine the impact health nationalisation has had on British healthcare and explore some of its inevitable – and often unintended - consequences.

CHAPTER IV

THE IMPACT, REALITY AND FAILURE OF STATE INTERVENTION IN BRITISH HEALTHCARE

Chapter four explores the history and record of the NHS. Analysing the service's roots and early aspirations, it goes on to examine its record concerning rationing, investment, class, employment and care. Ultimately, the chapter presents a comparative overview of the performance of the service in relation to the aspirations of its founding fathers and their guiding – egalitarian and statist - principles. In doing so it challenges conventional notions of market failure in health economics by raising the demonstrable spectre of government failure.

The Promise of the NHS

The idea of a free health service for all had first been mooted in Britain by Beatrice Webb in her minority report of the Poor Law inquiry of 1909.[1] However, it fell to Sir William Beveridge to articulate fully such a plan and to lay the foundations for such a service in his 1942 paper *Social Insurance and Allied Services*.[2]

Beveridge was the son of a British judge in India. Born in 1879 into a house staffed by twenty six servants, he was schooled at Charterhouse, studied mathematics and classics at Oxford and, in 1903 – at the age of twenty-four – became in effect an Edwardian social worker and researcher at Toynbee Hall - the university foundation for the poor in the East End of London.[3]

Oxford and Toynbee Hall triggered in Beveridge a lifelong interest in unemployment, state planning and social engineering. Beveridge later

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[1] Nicholas Timmins, (2001) The Five Giants: A Biography of the Welfare State, Harper Collins, London, p. 15.
[2] Social Insurance and Allied Services, Report by Sir William Beveridge, HMSO, 1942.
[3] Timmins, N., op.cit., p.12.

characterised his own progress at the time as being from "Oxford to Whitechapel, Whitechapel to Fleet Street, Fleet Street to Whitehall".[4]

Early on in this journey he visited Germany in 1907, where he studied the systems of compulsory social insurance for pensions and sickness which Bismarck had introduced in the 1880s. This venture proved to be a seminal moment in is life and one that was to have profound consequences for Britain.

In 1905 Beveridge became a leader writer at the Tory aligned Morning Post, a newspaper which later merged with the Daily Telegraph. Whilst there, he wrote on social policy issues advocating a national network of labour exchanges and state unemployment insurance.[5]

It was here that he first came to the attention of Winston Churchill who in 1908 brought him into the Board of Trade as a full time civil servant. During the next three years, Beveridge played a crucial role in the creation of a national network of labour exchanges of which he became the first director, and then in the formation of the world's first statutory insurance scheme against unemployment.[6]

With the arrival of the First World War, Beveridge moved to the Ministry of Munitions, where he was involved in deeply controversial moves to mobilise manpower and where he worked directly with Lloyd George. In 1916 he was moved to the Ministry of Food, becoming one of the chief architects of rationing and price control.[7]

Peace saw him leave the civil service to become the first director of the London School of Economics.[8] During a spell as Vice Chancellor of London

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[4] See the titles of Chapters I to III in: Beveridge, Lord, (1968) Power and Influence, Hodder & Stoughton.
[5] Timmins, N., op.cit., p.13.
[6] Ibid.
[7] Ibid., p.14.
[8] Ibid.

University he commissioned its totalitarian yet impressive Senate House – the building which Hitler earmarked to be his London headquarters.[9]

Although in 1937 he went back to Oxford as Master of University College, "his academic appointments did not remove him entirely from power and influence".[10] In 1934 he was appointed chairman of the Unemployment Statutory Committee, whose job it was to keep the insurance fund solvent, and in 1936 he was brought back into Whitehall to help devise the rationing that operated from 1940.

Beveridge was well connected with Britain's collectivist elite. R. H. Tawney, the Christian socialist thinker, was his brother-in-law and friend.[11] He knew well Sidney and Beatrice Webb, founders of the Fabian Society – who had also introduced him to Churchill.[12] Clement Attlee and Hugh Dalton, two men to whom would fall the job of finding the cash for Beveridge's plan, had been lecturers on his staff at the LSE.[13] Dalton was to be Attlee's first Chancellor of the Exchequer in 1945. As well as having worked with Churchill, Beveridge was a friend of John Maynard Keynes – whose new economics were to provide an intellectual justification for an ever expanding welfare state. He also knew Seebohm Rowntree.[14] And at Oxford his research assistant was a bright young economist called Harold Wilson.[15]

With the arrival of the Second World War Beveridge was eager to use his talent and past experience in government. Along with other veterans of First World War administration, he gravitated to Keyne's Bloomsbury house during the autumn and winter of 1939.[16]

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[9] Ibid.
[10] Ibid.
[11] Ibid. p.15.
[12] Ibid.
[13] Ibid.
[14] Ibid.
[15] Ibid.
[16] Ibid., pp.16-17. For more information see: Harris, J., (1977) William Beveridge, A Biography, Open University Press.

When Churchill became Prime Minister in May 1940, Beveridge wrote to remind him of their 'old association' and to offer his talents. He followed up with letters to Clement Attlee, Ernest Bevin and Herbert Morrison, the key Labour ministers in the newly formed coalition government. In July, Bevin asked him to carry out a brief survey – in a firmly non-executive capacity – of wartime manpower requirements.[17] Finally, Beveridge was doing the work he wanted to do.

The survey done, in December he again became a full-time civil servant as under-secretary for the military service department at the Ministry of Labour.

In February 1941 the Trade Union Congress had been to government to lobby about the chaotic and often contradictory array of government sickness and disability schemes that were on offer to workers. As a result an inter-departmental committee was proposed to Cabinet in April and Bevin offered its chairmanship to Beveridge.

On initial inspection, the terms of reference sounded modest:

> "To undertake, with special reference to the inter-relation of the schemes, a survey of the existing national schemes of social insurance and allied services, including workmen's compensation, and to make recommendations."[18]

However, Home Office and Ministry of Health officials had higher hopes and wanted a broader examination. The Treasury on the other had saw the committee in much more limited terms, and acting merely as a 'tidying up operation'.

Beveridge sided with the Home Office and the Ministry of Health. He too wanted a broader more visionary study and that is certainly what he set out to construct.

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[17] Timmins, N., op.cit., p.17. Also see: Harris, J., op.cit.
[18] Ibid., p.18.

In all, 127 pieces of written evidence were to be received, and more than 50 private evidence sessions held with witnesses.[19] But only one piece of written evidence had arrived by December 1941 when Beveridge circulated a paper entitled 'Heads of a Scheme' which contained the essence of the final report to appear a year later.

The initial paper opened with the key statement that was to stretch the original terms of reference up to and beyond their limit.

> "1 No satisfactory scheme for social security can be devised [without the] following assumptions.
>
> A A national health service for prevention and comprehensive treatment available to all members of the community.
>
> B Universal children's allowances for all children up to 14 or if in full-time education up to 16.
>
> C Full use of powers of the state to maintain employment and to reduce unemployment to seasonal, cyclical and interval unemployment, that is to say to unemployment suitable for treatment by cash allowances."[20]

Work on the committee proceeded at a pace during 1942 as witnesses were called and evidence taken. However, the credit for the report's popular impact may need to go as much to Janet Mair as to Beveridge himself. As Nicholas Timmins explains in his seminal *The Five Giants – A Biography of the Welfare State*:

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[19] Ibid., p.20.
[20] Much of this paper was reproduced in Fraser, D., (1973) The Evolution of the British Welfare State, Macmillan, p. 265.

> "Jessy, as Janet Mair was known, was the wife of David Mair, a somewhat austere mathematician and civil servant who was Beveridge's cousin. She and Sir William had become close before the First World War, Mrs Mair sharing...Beveridge's 'dreams and ambitions'. A powerful personality in her own right, she and Beveridge were to marry a fortnight after the report was published. They had, however, already scandalised the 'lady censors of the University world' when Mrs Mair moved into the Master's lodgings at University College at the outbreak of war."[21]

During the crucial stages of the report's compilation in the spring and summer of 1942, Jessy was staying with relatives in Scotland. According to Beveridge's biographer, Jose Harris, it was she who had greatly encouraged Beveridge not just to rationalise the existing insurance system but to lay down long-term goals in many areas of social policy.[22]

When the report was finally published on 1 December 1942 its reception was ecstatic. On the night before there were queues to buy it outside Her Majesty's Stationary Office's headquarters in London's Kingsway. The first 60,000 copies of the full report at 2s. 0d. a time were sold rapidly. Sales topped 100,000 within a month and more than 200,000 by the end of 1944. Although it is hard to believe that a majority of those who bought it made it through to the end - much of this 200,000-word document was heavy going, high on technical terms and detail – it was to have a profound impact on the course of history and the continuing rise of the British state.

What made its reputation and provided its impact was the twenty page introduction and the concluding twenty-page summary, separately published in a cut-down version at 3d. Combined with the full report this took sales of 600,000.[23]

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[21] Timmins, N., op.cit., p.22.
[22] Harris, J., op.cit., p. 387.
[23] Addison, P., (1975) The Road to 1945, Jonathon Cape, p. 217.

Overnight Beveridge became a popular national figure. However, if the report's impact at home was spectacular, it was also pushed heavily overseas by an initially enthusiastic Ministry of Information. Details of 'The Beveridge Plan' were broadcast by the BBC from dawn on 1 December in twenty-two languages. Copies were circulated to the troops, and sent to the United States where the Treasury made a $5,000 profit on sales.[24]

More copies were dropped into France and other parts of Nazi-occupied Europe where they caused concern at the highest level.

With his experience of journalism, government and academia, Beveridge made for a formidably intelligent and effective propagandist. Through broadcasts, articles and half-leaks – he was an occasional member of the massively influential radio 'Brains Trust' - he made very certain "that the world knew it was coming".[25]

As early as April 1942, a Home Intelligence report noted:

> "Sir William Beveridge's proposals for an "all-in" social security scheme are said to be popular."[26]

In the Autumn another Home Intelligence report stated that:

> "Three years ago, the term social security was almost unknown to the public as a whole. It now appears to be generally accepted as an urgent post-war need. It is commonly defined as "a decent minimum standard of living for all"."[27]

In October, Brenden Bracken, the Minister of Information, wrote to Churchill:

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[24] Cootes, R, J., (1984) The Making of the Welfare State, Longman, p. 79.
[25] Timmins, N., op.cit., p.40.
[26] Ibid., p.41.
[27] Addison, P., op.cit., pp. 215-216.

> "I have good reason to believe that some of Beveridge's friends are playing politics and that when the report appears there will be an immense amount of ballyhoo about the importance of implementing the recommendations without delay."[28]

He was right, Beveridge and his friends were playing politics and doing everything they could to expand the state. Whether consciously or otherwise, there is clear evidence that Beveridge understood the implications of his arguments and tactics. For example, in mid-November 1942, just a few weeks before the report's publication, he told the *Daily* Telegraph that his proposals would take Britain:

> "...half-way to Moscow".[29]

Significantly, after the war, two papers marked 'secret' and providing a detailed commentary of Beveridge's plan were found in Hitler's bunker. One ordered that publicity should be avoided, but if mentioned the report should be used as:

> '...obvious proof that our enemies are taking over national-socialist ideas'.[30]

The other report provided an official assessment of the plans as no 'botch - up':

> "...a consistent system...of remarkable simplicity...superior to the current German social insurance in almost all points".[31]

Although members of parliament from across the Labour, Liberal and Communist parties were clearly in favour of Beveridge's plans – and in particular the idea of a National Health Service – Churchill reacted on 21

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[28] Ibid., p. 216.
[29] Timmins, N., op.cit., p.41.
[30] Ibid., p.25.
[31] Fritz Grunder, Beveridge Meets Bismarck, York Papers, Vol. 1., p.69.

March 1943. In a broadcast entitled 'After the War' – his first major broadcast to concentrate on the home front – he promised:

> "...national compulsory insurance for all classes for all purposes from the cradle to the grave."[32]

It was therefore Churchill, rather than Beveridge, who defined the plans in terms of running 'from the cradle to the grave' as he signed the wartime coalition up to it.

In February 1944 the government published White Papers on a National Health Service and Employment Policy. It set up a Ministry of National Insurance, and delivered the 1944 Education Act. A housing White Paper followed in March 1945 and on 11 June, as virtually the final act of the coalition government, the Family Allowances Act became law.

From the outset the health White Paper, *A National Health Service*, was seen as bold, far reaching and crystal clear. It made clear that everybody:

> "'...irrespective of means, age, sex, or occupation shall have equal opportunity to benefit from the best and most up-to-date medical and allied services available'; that the service should be 'comprehensive' for all who wanted it; that it should be 'free of charge', and that it should promote good health 'rather than only the treatment of bad'."[33]

As such, it was now certain that a National Health Service, largely tax-financed, free at the point of use, and comprehensive, covering family doctors, dentists, hospitals and more would be made a reality.

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[32] For more information see: Addison, op.cit., p.228.
[33] Foot, Michael, Aneurin Bevan, A Biography. Vol. One: 1879-1945,Vo.l Two 1945-60, Four Square, 1966, 1973, p. 131.

Following the 1945 General Election, Labour's 146 majority was the largest the party had ever known. Upon arrival, Labour MPs horrified the Conservative benches by singing 'The Red Flag' in the Commons chamber.[34]

The appointment of Aneurin Bevan to the Ministry of Health by Prime Minister Clement Attlee was a gamble. Bevan was one of only two Cabinet ministers who had not served in the wartime coalition. "A stormy petrel" with "a magic all of his own", he was one of "the most hated – if also the most idolized – politicians of his time".[35] Above all else, this forty-five-year-old ex-miner, however, proved himself at the Ministry of Health to be:

> "...an artist in the uses of power".[36]

Bevan was to capitalise not only on the intellectual and institutional tides of previous decades – and in particular the all important work of Sir William Beveridge - but he also established the National Health Service in the wake of a greatly expanded war-time state. As Nicholas Timmins has commented:

> "By October 1939 the government had provided nearly 1000 new operating theatres, millions of bandages and dressings, and tens of thousands of extra beds in 'hutted annexes' some of which remained in use for more than two decades after the war. A national blood transfusion service had been created. As the war progressed, free treatment under the emergency scheme had gradually to be extended from direct war casualties to war workers, child evacuees, firemen and so on, until a sixty-two page booklet was needed to define who was eligible. Although the elderly and others remained excluded, between 1939 and 1945 'a growing section of the population enjoyed the benefits of the first truly "national" hospital service'".[37]

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[34] Timmins, N., op.cit., p. 102.
[35] Ibid.
[36] Morgan, K., O, (1992) Labour People – Hardie to Kinnock, Oxford Paperbacks, Oxford University Press, pp.204-5.
[37] Calder, A., (1969) The People's War, Jonathon Cape, pp. 538-9; Addison, op.cit, p. 179.

By March 1946, Bevan had drawn up proposals that were to form the National Health Service Bill. On the question of what to do with local municipal and independent voluntary hospitals his idea was 'revolutionary' and seemingly 'inevitable':

> "His answer...was to take the lot...into public ownership..."[38]

As a sign of the times, when the Bill was published in March 1946, it was not the idea of nationalising the hospitals but Bevan's proposals for general practitioners that caused the greatest reaction.

Bevan proposed that family doctors should be paid a basic salary and capitation fees on top. However, on this point, the BMA "exploded".[39] Doctors were concerned that the plans would over time lead to a full-time salaried service under either state or local government. As such, doctors would be reduced to civil servants, and clinical independence and freedom of speech gravely threatened. One commentator, Dr. Alfred Cox, a former secretary of the BMA wrote to the British Medical Journal declaring:

> "I have examined the Bill and it looks to me uncommonly like the first step, and a big one, towards National Socialism as practised in Germany. The medical service there was early put under the dictatorship of a "medical Fuehrer". This Bill will establish the Minister of Health in that capacity."[40]

Dr. Cox's views were shared by a high proportion of the profession. At a meeting of a thousand doctors in Wimbledon Town Hall shortly after the Bill was published, Bevan was called 'a dictator' and 'an autocrat'. "This Bill" argued one doctor:

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[38] Timmins, N., op.cit., p.113.
[39] Ibid., p.118.
[40] Ibid., p.119.

"...is strongly suggestive of the Hitlerite regime now being destroyed in Germany."[41]

Another person denounced the hospital proposals as:

"...the greatest seizure of property since Henry VIII confiscated the monasteries".[42]

Throughout the dispute ridden months between April 1946 and the appointed day on 5th July 1948 when the National Health Service would begin, the argument was repeatedly heard that Bevan's plans on health and in particular for the GPs were the "thin end of the wedge".[43]

As part of the process of Bevan's negotiations with the Royal Colleges, he eventually became persuaded that part-time consultants should continue to practice privately in NHS 'pay beds'. Without this concession on the part of the government there was a real risk that specialists would refuse to join the new state service and in Bevan's own words leave to establish "a rash of private nursing homes all over the country".[44]

Moreover, Bevan was also persuaded to provide merit awards – in addition to consultant's basic salaries, for those doctors whom their peers judged worthy. A decade later, Bevan at a private dinner in the House of Commons boasted in one of his famous asides that to create the NHS and with reference to the medical profession:

"I stuffed their mouths with gold".[45]

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[41] Ibid., p. 119.
[42] Foot, M., op.cit., p.143.
[43] Timmins, N., op.cit., p.112.
[44] Webster, C., (1988)The Health Services Since the War, Volume 1: Problems of Health Care. The National Health Success, Association of Community Health Councils, p.73.
[45] Charles Webster, Aneurin Bevan on the National Health Service, Welcome Unit for the History of Medicine, Oxford, pp. 219-22.

In 1948 just prior to the appointed day, the government issued a leaflet to every home in the country. It contained – in black and white - the promise that was the NHS. Extolling the virtues of the new National Health Service it assured the reader that the NHS:

> "...will provide you with all medical, dental and nursing care. Everyone – rich or poor – can use it."[46]

The key word here was the word *all*. The state was going to offer comprehensive, universal and unlimited healthcare for everyone, whatever their need.

In early July 1948 the Daily Mail stated:

> "On Monday morning you will wake up in a new Britain, in a state which 'takes over' its citizens six months before they are born, providing care and free services for their birth, for their early years, their schooling, sickness, workless days, widowhood and retirement. All this with free doctoring, dentistry and medicine – free bath-chairs, too, if needed – for 4/11d out of your weekly pay packet. You begin paying next Friday."[47]

The Reality of Rationing

Today, more half a century on, it is arguable that the NHS has never delivered upon its early promise. Beyond the simplistic world of media impression, rationing through a number of means has always been rife in the NHS and with patients often being denied the high quality treatment and care they require.

In reality, it did not take the 1945 Labour government long to realise that the NHS was not going to keep up with – or reduce as some had suggested –

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[46] Department of Health leaflet announcing the NHS, July 1948.
[47] Daily Mail, 3 July, 1948.

people's demand for healthcare.[48] As Celia Hall, medical editor of the Independent recalled in 1989:

> "I remember a Medical Officer of Health in Birmingham, now dead, telling me they were so terrified that there would be a stampede for everything free on the day that the staff arrived early and literally barricaded themselves into their offices, peering out. Needless to say, this being Britain, soon after 9 o'clock a neat, orderly and not very long queue of mothers and babies formed up outside."[49]

While a number of experts had popularised the view that there might be an 'initial surge' in demand for spectacles and false teeth and then demand would decrease it soon became clear that such theorising was wrong.

Within eighteen months of the service having been established, Bevan was himself admitting that there were problems:

> "I shudder to think of the ceaseless cascade of medicine which is pouring down British throats at this time."[50]

While he had been aware of the unpredictability of the costs of the service in advance, telling Dalton that it would take a full year's experience to know them, he had also initially insisted that the NHS's high costs would fall as the backlog of disease was treated.[51]

Back in 1944, Bevan's White paper, *A National Health Service*, estimated that the service would cost taxpayers £132 million per year. However, this was revised upwards to £152 million in 1946 and again to £230 million just before the Act came into force in July 1948.

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[48] Rudolf Klein, The Politics of the National Health Service, Longman, London, 2nd edition, 1989, p.35.
[49] Alice Law, recalling 5 July 1948; Peter Hennessy, (1992) Never Again, Britain 1945-51, Jonathan Cape, p. 174.
[50] Webster, Health Services Since the War, p. 145.
[51] Timmins, N., op.cit., p. 132.

In its first full year of operation - 1949-1950 - the NHS actually ended up costing £305 million and required a supplementary estimate of £98 million.[52]

The early estimates of expenditure were ultimately inaccurate not only because the government assumed that the service would account for a small and stable share of public expenditure but because their projections were based on extrapolations of pre-war spending levels which were mainly on cheaper preventative measures.

The inaccuracy of the estimates can be attributed to a number of factors. The first was that the early projections of cost assumed that demand would remain roughly constant, despite there being no price constraints on demand – the service being 'free' at the point of use.

Secondly, contemporary social and medical developments exacerbated the problems created by an absence of any price constraints on demand, not least because medial advances at the time meant that there was a dramatic expansion in the type and range of health services which could be made available. As Timmins has noted:

> "Streptomycin was not the only medical advance that became available. In the twenty-first century it is easily forgotten that the NHS has always had to absorb such costs to survive. In the service's first eighteen months other new antibiotics became available. So did tubocurarine, the muscle relaxant still in use today which rapidly widened the types of surgery which could be performed. Pernicious anaemia became treatable for the first time, new prophylactics became available for diphtheria, while cortisone, the first effective treatment for rheumatoid arthritis, was discovered. Many of these new treatments were both scarce and horrendously expensive. It was evidently impossible instantly to 'universalise the best'. It was, however, possible rationally to extend it by limiting the new treatments initially to specialist

[52] Rudolf Klein (1989) The Politics of the National Health Service, Longman, London, 2nd Edition, p.34.

centres before falling prices allowed their more general use: the NHS's first – and perennial – answer to the rationing issue."[53]

In many ways the NHS was designed to provide a style of health care that was more appropriate to the 19th century rather than the 20th century. Previous improvements in health had been brought about through large scale immunisation and better sanitation and nutrition. These measures had been relatively inexpensive, easy to administer and subject to large economies of scale.

The 20th century, however, characteristically saw the development of treatments for a range of degenerative conditions and most of these have tended to require a range of costly individual actions and medications.

Crucially, effective treatments for degenerative conditions have not lowered health costs in the way that the eradication of conditions like smallpox once did.[54]

The number of people most likely to suffer these degenerative conditions has steadily increased as life expectancy rates have improved, placing further pressures on healthcare. In 1901, for example, people over the age of 50 comprised just 14.8 per cent of the United Kingdom's population, whereas by 1951 they accounted for 27.6 per cent. By 1981 the figure had reached 31.8 per cent and continues to rise.[55]

Government realised early on that it could not afford a health service that was entirely free at the point of use. Although this was one of the founding principles of Bevan's NHS, it was actually abandoned within five years of the

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[53] Timmins, N., op.cit., pp. 131-132

[54] Jim Bourlet (1994) Rationing and the Future of UK Healthcare, London, Independent Healthcare Association, pp.2-3.

[55] David and Gareth Butler, British Political Facts 1900-1985, Macmillan Press, Basingstoke, 6th edition, 1986, p.235.

1944 White Paper. In 1949, an amending Act was passed to allow the levying of a one shilling charge on prescriptions.[56]

By 1950 the system was under such pressure that one commentator, Cecile Palmer, went so far as to state in his seminal *The British Socialist Ill-Faire State*:

> "Today, Great Britain is short of doctors and nurses. Our hospital services are being drastically economised, and building new ones to relieve the pressure of public demand is virtually suspended in consequence of largely inevitable cuts in our capital expenditure programmes. The much-publicised new clinics, which we were led to believe would solve most of the doctors' domestic and professional problems and incontestably make miserable patients happy, have not materialised and never will do so in a constipated socialist economy that is constantly under the necessity of robbing Peter to pay Paul."[57]

After the Conservative election victory of 1951, further charges were introduced for prescriptions, spectacles and dental treatment. Indeed, it was as far back as 1956 that the system of levying prescription charges by the number of items prescribed was first introduced.

The aim of these charging mechanisms was to simultaneously open a new source of funding revenue for the NHS whilst also deterring 'frivolous' demand for healthcare. But these measures proved to be grossly inadequate. For while there was some slowing in the rate of increase in the prescriptions issued, the revenue raised was never as significant as the Treasury would have liked.

In 1950-51, charges contributed less than one per cent to the NHS budget and even their largest contribution later in the decade was only 5.3 per cent.[58]

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[56] Jim Bourlet, op.cit., p.3.
[57] Royal Commission on the National Health Service, Cmnd 7615, 1979, p. 436.
[58] Klein, op.cit., p.39.

Another check to demand was a more deliberate rationing of supply – through scarcity rather than price. While doctors who worked in NHS hospitals had been encouraged at first to treat their patients according to need, and not to be deterred by financial considerations, the imposition of cash limits soon turned them into allocators of scarce resources.

More than minimal care was denied to cases where there was little chance of successful recovery, particularly to young children or the elderly with serious conditions. Indeed, health care for everyone else was provided sparingly by international standards. In the late 1970s for example coronary artery by-pass operations were performed about ten times more frequently pro rata in America than in Britain. And where these did not increase life expectancy, they tended to reduce adverse symptoms such as pain. While American doctors responded to complaints about pain, British doctors have tended to pay more attention to the probable increases in life expectancy, or the improvements in a 'quality of life' not always synonymous with an absence of serious discomfort.[59]

The supply of health care has again been rationed still further by queuing. Crowded waiting rooms are common in most general practices and out-patient departments. And queues have become a fact of life for in-patients, often with long waiting periods for those operations given priority. Even in the 1980s and 1990s, after years of reforms designed to cut waiting lists, the median time to have a hernia repaired was more than 10 weeks and 14 for having a cataract treated.[60] The waiting times for many other less urgent procedures have usually been measured in months.

Certain health services have never been provided by the NHS, reducing the demand on its resources still further. Most forms of cosmetic surgery have rarely been available and face lifts, liposuction, hair transplants and sex

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[59] Henry J Aron and William R. Schwartz, The Painful Prescription: Rationing Hosptial Care, Brookings Institute, Wahsington DC, 1984, p.67.
[60] Klein, op.cit., p.155.

change operations have never been provided except where they have been deemed necessary for reasons of health or as part of some other form of treatment. Other services have been provided on a minimal basis too. Much psychiatry, the treatment of infertility and substance misuse services remain cases in point.

Against the popular view that the NHS exists to provide 'free' and virtually unlimited healthcare, history demonstrates that the supply of NHS services has always been limited in significant ways. In reality, people have never had an absolute right to free and equal treatment on demand in the NHS. What they have had – in the main – is an unlimited right of access to a waiting list from which – with a few exceptions – they will not be excluded.

This right of access is not equivalent to a right to treatment, as any notional right to treatment has little value in practice if it is only available at the end of a two year waiting time. The right to healthcare is unlimited in the long term, but is strictly limited in the short term when healthcare is actually required, at the very least, to relieve pain or discomfort.

The Reality of Investment

As part of the 1946 Act's nationalisation process, NHS hospital building was to be financed by central government grants and funded out of general taxation and national insurance contributions.

However, in the early years, the government made very little investment in its nationalised health estate. Not until the mid-1950s did a gradual release of funding allow new hospital building in some areas – and only then on a very limited basis.

Then, in July 1960, Enoch Powell became the Minister of Health. He arrived at a time of growing economic concern which in government circles

culminated in the 1961 Plowden report.[61] It attempted to reconcile the Treasury's requirement for an annual budget in order to control spending with the demands of state welfare policy, including the NHS. The result was a five-year rolling programme which was approved each year by the Expenditure Survey Committee but was then subject to revision in each annual bid – the so-called PESC round.

It was this work that started to address the fundamental issue of expenditure and the NHS's problems concerning capital investment. For during the first decade of the NHS, not a single new hospital had been built. None had even been approved until 1956.[62]

In the early 1960s the hospital estate that was in use was either that inherited from the independent sector or from local government. To address the problem Powell raised a number of NHS charges:

> "...including a doubling of the prescription charge from 1s. od. To 2s od (10p) an item."[63]

The higher charges were in part to finance the great 'Hospital Plan' which was finally launched in January 1962. It aimed at a £500 million programme over a decade to build 90 new hospitals, drastically remodel 134 more and provide 356 further improvement schemes - each costing over £100,000.

While there had been a few hospital extensions, new theatres, out-patient departments and other refurbishments, in the thirteen years from 1948 only £157 million had been spent nationally: well under a third of the figure now being proposed.

Explaining the parlous situation Timmins has observed:

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[61] Report on the Control of Public Expenditure (The Plowden Report), Cmnd 1432, HMSO, 1961.
[62] A Hospital Plan for England and Wales, Cmnd 1604, 1962, pp. 1-2, 13.
[63] Timmins, N., op.cit. p. 208.

> "NHS hospitals had, quite simply, lost out to new schools and housing. In the fourteen New Towns, for example, new schools had to be provided for children; patients, however, could still be told to travel for treatment and in 1953 they had boasted 'not a hospital between them'."[64]

In his 1956 work, *The Future of Socialism*, Anthony Crossland argued that:

> "The voters, now convinced that full employment, generous services and social stability can quite well be preserved, will certainly not relinquish them. Any Government which tampered seriously with the basic structure of the...Welfare State would meet with a sharp reverse at the polls."[65]

However, less than a decade later, the unimaginable was being thought of as a serious option. As Britain's economic performance failed to keep pace with politician's promises - and rising public expectations - so views began to polarise on the post-war settlement and the NHS.

In 1957 the Institute of Economic Affairs (IEA) had been founded. An independent think tank dedicated to the promotion of classical libertarian ideas, by the early to mid-1960s it was promoting what were later to be become seminal ideas concerning the necessary break up of state provision through various forms of tax relief, privatisation and private insurance. Throughout the 1960s the ideas and influence of the IEA began to permeate British political consciousness.

In 1961 the IEA published Health Through Choice by D. S. Lees, an economics lecturer at what was later to become the University of Keele. He argued that medical care was essentially a consumer good 'not markedly different' from others'.[66] And he went on:

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[64] Ibid., pp. 209-210.
[65] Anthony Crosland, (1956) The Future of Socialism, Cape, p. 61.
[66] Timmins, N., op.cit., 250-251.

> "Spending on the NHS had probably been lower than consumers themselves would have chosen precisely because politicians rather than the market made the decisions."[67]

The answer he prescribed was for the state to:

> "...move away from taxation and free services to private insurance and fees."[68]

Lees argued for tax concessions to be granted to those who could afford to provide for themselves and for means-tested assistance to be given to the "dwindling minority" who could not.

By the mid-1960s the IEA was promoting the idea of vouchers for healthcare and openly expounding the virtues of private provision. Although such ideas were judged to be politically unacceptable at the time by those in the political mainstream, such views did slowly permeate Britain's political conversation.

From the mid-1960s onwards evidence mounted that the consensual pragmatism of the post-war settlement was under strain. As Britain's economic performance declined - and academics, journalists and other opinion formers questioned its overall direction - so government's ability to keep up with required NHS investment particularly in terms of capital expenditure came under pressure.

The 1964 balance of payments crisis; the sterling crisis of 1965 and 1966; the devaluation of the pound in 1967; the industrial strife of the early 1970s; the International Monetary Fund loan of 1976; the winter of discontent in 1978-9. All these milestones act as a testimony to the fact that the ambitions of the political class were no longer being met given the parlous realities of the nation's economy.

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[67] Ibid., p. 250.
[68] Ibid.

> "By the mid-1970s, the wave of capital investment that had inaugurated the hospital plan for the NHS was effectively at an end. The squeeze on capital was reflected across all government departments in which, between 1974 and 1998, total net annual capital expenditure fell from £28.8bn to 3.3bn in 1998 prices."[69]

Today, much of the NHS estate that people see was inherited in the late 1940s and therefore remains largely unchanged:

> "Today, the infrastructure still retains many pre-NHS features and a significant proportion of the stock predates the First World War. Capital spending has been insufficient to either replace or maintain outworn and outmoded buildings."[70]

This reality is significant because Beveridge had originally believed that the NHS would raise the general level of health and fitness of the nation - and increase national prosperity through a reduction of sickness absence – to such a point that it would fundamentally raise people's productivity.

As such, he believed the NHS would broadly pay for itself – or at the very least not be subject to endlessly rising costs. In his 1942 report he had asserted:

> "...there will actually be some development of the service, and as a consequence of this development a reduction in the number of cases requiring it".[71]

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[69] Gaffney, D., Pollock, A. M., Price, D., Shaoul, J., NHS Capital Expenditure and the Private Finance Initiative – expenditure, (1999) HM Treasury, Financial Statement and Budget Report 1999-2000. London, HMSO.
[69] Gaffney, D., et al., Ibid.
[69] See Timmins, N., op.cit. p. 260.Expansion or Contraction, British Medical Journal, 3 July 1999, 31:48-51. Also see: Table B28: Historical series of government expenditure, (1999) HM Treasury, Financial Statement and Budget Report 1999-2000. London, HMSO.
[70] Gaffney, D., et al., Ibid.
[71] See Timmins, N., op.cit. p. 260.

Most importantly of all, he even went so far as to assume that the NHS would actually cost the same amount of money in 1965 as he tentatively assumed it would cost in 1945 - £175m.[72]

In reality, the economic crisis of the 1960s and 1970s led to attempts to find sources of financing other than government borrowing. And in 1973, regional health authorities were allowed for the first time to use the proceeds from land sales for investment.[73]

As a result of gradual and persistent economic decline – and as Declan Gaffney, Allyson Pollock, David Price and Jean Shaoul have pointed out - although the principle of major hospital investment was initially adopted in the NHS under Powell's 1962 hospital plan, even in the 1990s:

> "The plan...remains unfulfilled, with only a third of the projected 224 schemes completed, and a third not yet started."[74]

Despite depressed prices in the late 1980s, land sales have become an increasingly important source of capital funding over recent decades. By 1998-9, they accounted for over a third of NHS capital expenditure.[75]

Since 1992, most new capital investment in the NHS has been arranged under a scheme somewhat ironically known as the private finance initiative (PFI). Here the private sector designs, builds, finances, owns and operates key areas of NHS provision – including some services.[76] Although this policy was initially adopted by John Major's Conservative government, it has since been actively embraced by Tony Blair's Labour administration:

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[72] Cmnd 6404, p. 105; S. P. W. Care in Oxford Textboo of Public Health Vol. I., 1984, pp. 13.14.
[73] Meara, R., (1991) Unfreezing the assets: NHS estate management in the 1980s, King's Fund Institute Research Report 11, London, Kings Fund.
[74] Gaffney., D., et al., op.cit.
[75] Ibid.
[76] For more see: Ibid.

> "In the absence of new capital, NHS trusts have no other recourse but to pursue the private finance initiative to finance new investment."[77]

In recent years, under the general rubric of public private partnership (PPP) the government has championed a whole raft of market-oriented NHS reforms. In 2000 the Secretary of State for Health, Alan Milburn, signed a Concordat with the representative body of Britain's, by now re-emergent, independent health and social care sector – the Independent Healthcare Association (IHA).[78] Under this agreement, the NHS could send its patients to independent hospitals and clinics for treatment and care.[79]

Between 2000 and 2003 more than 250,000 NHS funded patients received treatment and care in the independent sector and others were sent to private hospitals abroad.

In 2001, the government made it clear that it wanted the private sector to design, build and operate a new generation of Diagnostic and Treatment Centres (DTCs) for the benefit of NHS funded patients. More recently, the government named the private companies that would bid for the contracts. All of them were foreign new market entrants – thereby underlining a new era of competition in healthcare provision.[80]

Again in 2001, the government also made it clear that it wanted to establish a new generation of independent Foundation Hospitals. As such, it wanted the best NHS hospitals to be "set free" from Whitehall control and to have a greater say over how they developed and from where they raised their capital.[81]

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[77] Ibid.
[78] The Independent Healthcare Association was the main representative body of the UK's independent health and social care sector. After more than fifty years of work it closed in 2004.
[79] For a detailed overview of the Concordat and how it came about see: Allyson M., Pollock, (2004) NHS plc: The Privatisation of Our Healthcare, London, Verso, pp.66-68.
[80] Ibid., pp.68-71.
[81] Ibid., pp.71-77.

Overall, the historic direction of travel in the NHS is clear. Selling off NHS land, PFI, PPPs, the Concordat with the IHA, DTCs and Foundation hospitals point to an increasingly privatised future. Slowly, the NHS is being redefined as a funder of healthcare but not as a provider – or owner - of the facilities in which the services are delivered.

The Reality of Class

In theory the National Health Service exists to treat the whole population and people of all social classes in an equitable manner, and according to need. However, in practice the historical evidence suggests that this has rarely happened.

Clearly, the health of the population as a whole has improved in recent decades. By the early 1990s, a baby boy could expect to live to seventy-three and a girl to seventy-nine.[82] More than 50 per cent of boys and more than 60 per cent of girls now have a life expectancy of eighty.[83] Measures such as height, nutrition and dental care are all similarly improved.

However, while such facts are loudly trumpeted by politicians as achievements of the NHS, such views often deceive as much as they enlighten:

> "Lower occupational groups have been found to experience more illness which is both chronic and incapacitating. Although it is taken for granted that sickness will happen to almost everyone sooner or later, it seems that lower occupational groups experience it earlier and this must be seen as a major inequality in a welfare society. Other indirect measures of affluence and poverty, such as household-based

[82] NHS Statistical Bulletin, 18 August 1995.
[83] Michael Benzeval, Ken Judge and Margaret Whitehead, Tackling Inequalities in Health, Kings Fund, London, p. 10.

> classifications and employment status, also highlight inequalities in health."[84]

Almost all health indicators confirm the persistent association between the prevalence of ill health and poor social and economic circumstances. The 1981 census revealed, for instance, that the premature death rate was twice as high in the lowest social class as in the highest.

Using the Registrar General's classification, the life expectancy for a child with parents in social class V - unskilled manual - is over seven years less than for a child whose parents are in social class I - professional. Male manual workers have premature death rates 45 per cent higher than non-manual workers.[85] The number of premature deaths connected with manual work is greater than the total number of deaths from strokes, infectious diseases, accidents, lung cancer and other respiratory diseases combined.[86]

Significantly, the socio-economic differences in mortality are not simply confined to a few isolated diseases associated with particular occupations or lifestyles. Of the sixty-six 'major list' causes of death among men, sixty-two are more common in social groups IV and V than among all others. And of the seventy major causes for women, sixty-four are more common in groups IV and V.[87]

Equally important in all of this is the persistence, despite the existence of the NHS, of inequalities in access to health care. For example, a study in Newcastle in 1985 showed that dental services were more widely available to residents of affluent areas than to those of the poor areas designated 'priority' by the Department of Health.[88]

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[84] Margaret Whitehead (1992) The Health Divide, Penguin, London, p. 263.
[85] Andrew Adonis and Stephen Pollard (1997) A Class Act: The Myth of Britain's Classless Society, London, Hamish Hamilton, p.171.
[86] Ibid.
[87] Ibid., p.172.
[88] Ibid., p.278.

Analyses of GP consultations have shown that higher social class patients invariably receive more sophisticated explanations and details of their treatment than lower social class patients.[89] And that the middle classes spend more time on average with their GP than those with working-class backgrounds.[90] There is also clear evidence that classes I and II are more likely to be referred to specialists by their GP than classes IV and V.[91]

In 1993, there were 8.4 full-time GPs per 10,000 patients in Manchester, compared with only 5.6 in Rotherham.[92]

Julian Le Grand has shown that – relative to need – professional and managerial groups receive more than 40 per cent more NHS spending per illness episode than those people in semi – and unskilled jobs. Those in the highest income groups who report their health as 'not good' use 2 per cent more GP services and 17 per cent more in-patient services than those in the lowest groups.[93]

It is much the same for primary care. Individuals from areas with high deprivation have a low uptake of immunization[94] and there is a lower utilization of health promotion clinics among poorer social and economic groups.

Researchers in Glasgow even discovered that clinical investigations for heart disease were performed more frequently on patients from more affluent neighbourhoods – despite their having a lower incidence of such disease.[95]

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[89] Ibid.
[90] Michael Benzeval, Ken Judge and Margaret Whitehead, (1995) Tackling Inequalities in Health, London, Kings Fund, p.104.
[91] Ibid.
[92] Ibid,. p.99.
[93] Ibid., p.102.
[94] Andrew Adonis and Stephen Pollard, op.cit., p.179.
[95] Ibid.

Commenting on the NHS's legitimacy Andrew Adonis and Stephen Pollard concluded in their 1998 book, A Class Act: The Myth of Britain's Classless Society:

> "...in reality the NHS owes its effectiveness and popularity in large part to the fact that it is not egalitarian. The comfortably off revere the NHS in no small part because they get a good bargain out of it, and are thus happy to feel good about themselves by continuing to pay for what they are told is a subsidy to the poor."[96]

The Reality of Employment

More than half a century on from its inception the NHS faithfully exhibits the full range and dynamics of Britain's class hierarchy. As the largest employer in the country, and the single most important pillar of the welfare state, the service employs around 1 million people – or 3.5 per cent of all those in work.[97] A microcosm of class structure, Adonis and Pollard, assert:

> "At the top of the NHS are the hospital-based consultants (at the very top are the consultants of the London teachings hospitals)... Below the consultants is the upper middle class of the medical profession – the senior managers, who may earn as much as the consultants but who are the nouveaux riches of the service. Next comes the middle middle class, the GPs – some through choice, some because they have not quite made it. An increasing number of these are female – often because women realise pretty soon that they are unlikely to make it up the hospital career ladder. There is then a dramatic drop to the skilled, lower middle class: the nurses, therapists, technologists and technicians, who are mainly female. And below them is the proletariat – the auxiliary, ancillary and service personnel, who are overwhelmingly female."[98]

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[96] Ibid., p.180.
[97] Ibid., p.155.
[98] Andrew Adonis and Stephen Pollard, op.cit., pp.155-156.

Over 250 hospital consultants earn from the NHS alone £102,240 per annum.[99] And above that are those who are employed for specific talents that are in short supply in an area and who, according to one trust, earn "up to £20,000 above the NHS maximum".[100] Brian Hanson, chairman of Hartlepool and Peterlee Hospital Trust, has described the inflation in consultants' pay:

> "It is a common problem nationwide that hospitals have in getting suitably qualified staff. Some trusts have hired consultants at double the going rate."[101]

In 1996, NHS consultants were contracted with a basic salary from £42,000 to £54,000 a year. But any consultant who took home only his basic salary would be a very disappointed man (and man is what 82 per cent of them are). For, in what Ray Rowden, the former director of the Institute of Health Services Management has described as 'the biggest fraud since the Mafia', consultants award each other merit payments of up to another £51,710.[102]

> "Not bonus payments for good work, determined annually as in most comparable walks of life; but merit payments, approved once, and awarded for the rest of the career. And they do this through a system which, since its inception with the coming of the NHS, has remained secret, with unpublished criteria."[103]

Doctors from ethnic minority backgrounds are far less likely to be given consultant jobs than whites. After examining 418 vacancies in forty-five NHS Trusts, in 1991 and 1992, in three specialities where ethnic minorities were rare (general medicine, surgery and geriatrics), the Commission for Racial Equality (CRE) found that out of 147 consultant vacancies, 53 per cent of applicants were from ethnic minorities and 27 per cent of the appointments,

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[99] The Times, 10th January 1996.
[100] Ibid.
[101] Ibid.
[102] Andrew Adonis and Stephen Pollard, op.cit., p.164.
[103] Ibid., p.164.

and of 130 senior registrar vacancies, 37 per cent of applicants were from ethnic minorities and only 17 per cent of appointments. The CRE concluded:

> "The disparities in success rates...were so marked and consistent, and the omission of procedural safeguards too routine, that the possibility of discrimination cannot be ignored."[104]

Below the elite of consultants comes the medical middle class – the GPs. From the beginning of the NHS, GPs used their influence to avoid a salaried service. Instead, they have preferred to keep the benefits of self-employment and payment on the basis of fees and allowances.

The government sets an 'intended annual net remuneration' of £44,770, and expects to take-home pay to average out at £59,410. But as a guide to real pay the official figure is often of limited use. For instance, in 1995 10 per cent of GPs took home less than £24,000. So, just as there is a hierarchy of consultants, so there is with GPs. As one in-house guide to the medial profession – *Official Doctor/Patient Handbook* – puts it:

> "The range of pay is enormous, probably varying from as low as £20,000 for the struggling, often foreign, inner-city single-handed doctor with a very small list to as high as £100,000 for the slick, Home Counties, business oriented doctor who is running three nursing homes."[105]

Pay is supposedly determined by the number of patients on a GPs list, together with a multitude of 'weighing' factors such as patients' age.

> "But for those lucky enough to work in a large rural area, dispensing their own presriptions and with long car journeys (to take advantage of

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[104] Appointing NHS Consultants and Senior Registrars: Report of a Formal Investigation, Commission for Racial Equality, April 1996.
[105] Andrew Adonis and Stephen Pollard, op.cit., p.166.

generous mileage allowances), income can increase by around 25 per cent."[106]

Today, the NHS is no longer run just by its doctors. Managers' power has increased dramatically in recent years – as has their pay. As Adonis and Pollard again note:

> "Before the NHS reforms of 1988 and the introduction of trusts, each unit had a general manager on about £35,000 p.a. Cleaners earned just under £6,000. Now, the average chief executive's pay is about £60,000, with some on over £100,000. Cleaners' pay has also increased. It is now just over £6,000. Since 1979 the pay of medical practitioners and nurses has improved, with doctors starting from an already high base. From an already low base, the position of porters and orderlies has deteriorated far more than that of the unskilled in the economy as a whole."[107]

Half of the people who work in the NHS are nurses. Nine out of ten of these are women. Nurse salaries account for 27 per cent of total NHS spending.[108]

For many years nurses were thought of as being just a step up from porters and orderlies, and quite distinct from the medical professions. While the doctors' car park is considered essential, nurses need only travel by bus.

In recent years, the traditional view of nursing has begun to change and nurses have asserted their case for higher status within the NHS.

> "The modern teaching hospital nurse, with her new education – her A levels and sometimes a degree, and her state of the art training undertaken through a college of higher education – is too qualified to

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[106] Ibid., p.166.
[107] Ibid., p.167.
[108] Ibid., p.168.

waste her time on emptying bedpans, dressing wounds and preventing bedsores. That is now for the ancillary staff."[109]

The nurse, according to the *Official Doctor/Patient Handbook*:

> "...who should be doing the nursing sits at the nursing station pretending to be a doctor...The nurses...are sitting at their consoles pretending to read ECGs and to interpret complex biochemical investigations. They do not take responsibility for these "interpretations", but drive the doctors mad with their helpful suggestions."[110]

The NHS has more women employees than any similar organisation. Women represent more than 75 per cent of non-medical staff and 45 per cent of general managers. Yet they account only for 28 per cent of chief executives and senior managers and 18 per cent of consultants. Importantly, there are almost no black or ethnic minority managers. The women who do make it to the top jobs have, as a group, far fewer family ties than their male counterparts. Among top NHS managers, 50 per cent of women have no children, whereas for men, this is true only for some 7 per cent.

Again, among support staff, 85.9 per cent of clerical workers and more than 60 per cent of ancillary staff are female.

If one looks at the NHS from the inside, however it is staffed and organised, the reality is clear.

> "...if we look at how it is structured, and at those who work in it – we can see that it is indeed a fair microcosm of Britain's class structure. Just as the classless society is itself a myth, so too is the comforting classless NHS."[111]

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[109] Ibid., pp.168-169.
[110] John Duckworth, (1994) The Official Doctor/Patient Handbook, London, Harriman House, p.142.
[111] Andrew Adonis and Stephen Pollard, op.cit., p.169.

The Reality of Care

Today, the NHS has one million people on waiting lists and around another 200,000 people trying to get onto them.[112]

In NHS hospitals, more than 10 per cent of patients pick up infections and illnesses they did not have prior to being admitted.[113]

And according to the Malnutrition Advisory Group up to 60 per cent of NHS hospital patients are under-nourished during inpatient stays.[114]

In many areas, it is increasingly difficult for people to get an appointment with an NHS GP – or to even find an NHS dentist.[115]

The old are particular victims of the NHS. A recent King's Fund study, based on a survey of managers in hospitals, primary care groups, community trusts and social services departments, found evidence of persistent ageism in the way the NHS allocates resources and priorities treatments.[116] An American study found that:

> "British elders are frequently denied access to expensive technologies from which they are likely to benefit".[117]

The interim Wanless Report into NHS financing confirmed the low priority status of services for the old, including the lack of effective and integrated support for many patients.[118]

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[112] Estimate from the Independent Healthcare Association, May 2002.
[113] Department of Public Health & Policy, London School of Hygiene & Tropical Medicine, Research Briefing: Hospital Acquired Infections, No.5, London, 2001.
[114] See: http://www.nhs.uk/nhsmagazine/archive/apr/features/this16.htm The MAG's report was released on 11 November 2003.
[115] Alison Hardie and Ian Johnston, 1 February 2005, 'Vicious circle of blame over dental crisis' The Scotsman. Also see: Andrew Adonis and Stephen Pollard, op.cit., p.179.
[116] January 2002, Old Habits Die Hard, London, Kings Fund.
[117] Angus Deaton and Christina Paxton, Mortality, Income and Income Inequality Overtime in Britain and the United States, National Bureau of Economic Research, Working Paper No. 8534, Issued in October 2001. See: http://www.nber.org/digest/jan02/w8534.html

Again, according to one major study, patients who have major surgery in the NHS are four times as likely to die as those in America.[119] The comparison of care, which reveals a sevenfold difference in mortality rates in one set of patients, concluded that hospital waiting lists, a shortage of specialists and a lack of intensive care beds are to blame.

> "Mounting evidence suggests that patients who are most at risk of complications after an operation are not being seen by specialists, and are not reaching intensive care units in time to save them."[120]

A team from University College London (UCL) and a team from Columbia University in New York jointly studied the medical fortunes of more than 1,000 patients at the Mount Sinai Hospital in Manhattan and compared them with nearly 1,100 patients who had undergone the same type of major surgery at the Queen Alexandra Hospital in Portsmouth. The results:

> "...showed that 2.5 per cent of the American patients died in hospital after major surgery, compared with just under 10 per cent of British patients. They found that there was a sevenfold difference in mortality rates when a subgroup of patients – the most seriously ill – were compared."[121]

Commenting on the results, Professor David Bennett, head of intensive care at St Georges NHS Hospital in London, said:

> "There are substantial number of patients each year who die, who might otherwise have survived had they got the appropriate kind of care after surgery."[122]

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[118] Derek Wanless, November 2001, Securing Our Future Health: Taking a Long-Term View, London, HM Treasury.
[119] Tim Utton, 8 September 2003, 'NHS death rates four times than US', Daily Mail, London.
[120] Ibid.
[121] Ibid.
[122] Ibid.

Back to the Future: The Rediscovery of Independent Healthcare

One cannot open a newspaper today without reading about the pressures, strains and failures of the NHS. Higher expectations, new technology and the manifest failings of an overly-politicised monopoly service mean that politicians are eager to move away from the old methods of top-down governmental control in health and across [123]welfare. As a recent Secretary of State for Health, Alan Milburn, commented:

> "For fifty years the NHS has been subject to day-to-day running from Whitehall. The whole system is top down. There is little freedom for local innovation or risk taking....A million strong health service cannot be run from Whitehall. Indeed, it should not be run from Whitehall. For patient choice to thrive it needs a different environment. One in which there is greater diversity and plurality in local services which have the freedom to innovate and respond to patient needs. Our reforms are about redefining what we mean by the National Health Service. Changing it form a monolithic, centrally-run, monopoly provider of services to a values-based system where different health care providers – in the public, private and voluntary sectors – provide comprehensive services to NHS patients... Who provides the service becomes less important than the service that is provided."[124]

Today, the NHS seems destined to remain a key funder and regulator of health services for the foreseeable future but, significantly, it no longer seems destined to remain the owner of the facilities in which healthcare is provided.

Rekindling notions of consumer choice, political statements across the party political spectrum increasingly stress that healthcare should be delivered by a

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[123] Marsland, D., (1996) Welfare or Welfare State?: Contradictions and Dilemmas in Social Policy, Basingstoke, Palgrave Macmillan

[124] The Secretary of State for Health, the Rt. Hon. Alan Milburn MP, speech to New Health Network, London, 15 January 2002.

pluralistic range of providers who offer genuine diversity. As Alan Milburn again asserted:

> "...just because patients might be treated in a BUPA hospital today or a Foundation Hospital tomorrow that does not mean they cease to be NHS patients. Quite the reverse, patients remain NHS patients treated on NHS principles with care that is free and available according to need. The NHS is not its bricks and mortar. It is not a set of structures. It is fundamentally a set of values. An ethos if you like. We should be resolute in our defence of the values of the NHS but not of its outdated structures."[125]

There are many economic, technological, and cultural forces undermining the service as it was traditionally conceived. Nevertheless, as patients' expectations continue to rise alongside ever higher living standards so larger numbers of people are finding the unresponsive nature of the old state system unacceptable.

As people have become less tolerant of poor service, and less willing to act as passive recipients 'grateful for what they receive', what is now true in so many areas of life is rapidly becoming apparent in healthcare. Dr. Tim Evans of the Independent Healthcare Association commented, considering recent government health reforms:

> "After years of shunning liberal, market based, solutions in healthcare it is this Labour government that has introduced a concordat with the independent sector, whereby NHS-funded patients can receive treatment in independent hospitals. It is this government that is mobilising private hospitals on the continent for the benefit of NHS-patients. And it is Labour that is now planning to return NHS hospitals to the pre-1948 world of genuine independence from the state under the rubric of not-for-profit Foundation Hospitals."[126]

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[125] Ibid.
[126] Quote from a recorded interview with the author in April 2002.

In many ways, people's attitudes to healthcare have already changed. In a less deferential age where ever larger numbers of people have university educations, and consumer information flows freely on the internet, people are more aware of their choices - and their powers of exit. On the funding front, Evans continues:

> "Perhaps most importantly of all, it is this government which is overseeing a funding revolution in private health spending which, as yet, has not been fully explored..."[127]

In 2003, Labour politicians publicly claimed that it is only the Conservatives who want to encourage various forms of private health funding. Yet under Labour's governance, seven million people have private medical insurance and another seven million people are covered by private health cash plans. Millions more choose from a wide range of other options such as acute self-funding and paying privately for a range of alternative therapies.

> "In the year 2000, more than a quarter of a million people chose to self-fund for independent acute hospital surgery and treatment without any insurance at all. Instead, they simply paid cash or via their credit cards."[128]

In contrast to the original promise that the NHS "would provide all medical, dental and nursing care"[129] :

> "In dentistry, more than a third of the population has now abandoned the NHS and relies solely on independent sector treatment. And more than eight million people pay privately for a range of complimentary medical therapies every year".[130]

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[127] Quote from a recorded interview with the author in April 2002.
[128] Data from the Independent Healthcare Association.
[129] This quote is from a leaflet describing the role of the NHS delivered to every British home in July 1948. It was produced by the Ministry of Health.
[130] Independent Healthcare Association data May 2002.

According to research published in the Daily Telegraph[131], more than 3.5 million trade unionists – more than 50 per cent of the Trade Union Congress's 6.8 million members – now enjoy the benefits of private health cash and medical insurance schemes. The movement reportedly even has its own web site at www.tradeunion-privatehealth.org.uk [132]

At a time when the country's political class is trying to get itself off the hook of past political promises in health by exploiting the rhetoric of public private partnerships, many independent sector organisations already have formal agreements with trade unions or have large numbers of trade unionists in their memberships.

Some schemes offer private medical, permanent health or critical illness cover. Others offer private health cash plans that pay for services that include items such as dentistry, ophthalmics, physiotherapy, chiropody, podiatry, maternity services, allergy testing, hospital in-patient stays, nursing home stays, hospital day case admissions, convalescence, home help, mental health and psychiatric treatment, and even the use of an ambulance.

Today, independent sector healthcare schemes abound and most are in the not-for-profit tradition. A cursory survey includes the following organisations:

The Benenden Hospital - www.thesociety.co.uk - friendly society scheme serves 1 million British Telecom, Post Office and Civil Service workers and their families. Established in 1905, the Benenden is one of the largest independent hospitals in the country. It works in partnership with a national network of other not-for-profit independent hospitals and has a close relationship with many tens of thousands of trade unionists.

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[131] Daniel Kruger, 11 September 2001, 'Why half trade union members have private health', London, Daily Telegraph.
[132] This web site existed between 2001 and 2004.

The Bristol Contributory Welfare Association is a not-for-profit organisation established in 1935. It offers a range of private health cash benefits and private medical insurance products.

BUPA - www.bupa.com – is a mutual offering a wide range of private medical insurance and health cash benefits. It has a national network of more than 35 hospitals and 200 care homes. Established in 1947, the British United Provident Association is the amalgamation of seventeen historic provident associations and today covers more than 3 million people - many of whom are trade union members.[133]

The Birmingham Hospital Saturday Fund is a mutual that specialises in private health cash benefits. It has 150,000 workers in membership, a high proportion of whom are trade unionists. It has a formal partnership arrangement with Standard Life Healthcare – www.standardlifehealthcare.com

The Civil Service Healthcare Society - www.cshealthcare.co.uk - was founded in the 1920s. It has more than 25,000 people in membership. A mutual offering private medical insurance, its members are primarily workers in the public sector.

The Communication Workers Friendly Society - www.cwfs.co.uk - is a mutual offering private sickness benefits. Having a special relationship with union members in the postal and telecommunications industries, it is strongly aligned with the Communications Workers Union.[134]

Dentists Provident Society - www.dps-ltd.co.uk - is a mutual offering permanent health insurance, private health cash benefits and accident and sickness benefits. Most members are dental surgeons - many of whom have traditionally worked in the NHS.

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[133] BUPA estimate that some 10 per cent of their members are in trades unions and professional associations.

[134] The Communications Workers Friendly Society is open about this relationship on its web site: www.cwfs.co.uk

Exeter Friendly Society - www.exeterfriendly.co.uk - offers private medical insurance and is one of the best known healthcare friendly societies working in Britain.

Health Shield - www.healthshield.co.uk - is a friendly society with more than 120 years of experience. It offers a range of private health cash benefits.

Health Sure Group - www.healthsure.org.uk - is a mutual offering private health cash benefits. It has many members of the Unison trade union in its membership.

Holloway Friendly Society - www.holloway.co.uk – specialises in permanent health insurance and sickness benefits. Traditionally, it has a close relationship with trade unionists in customs and excise.[135]

The Hospital Savings Association www.hsa.co.uk is a mutual organisation that offers private health cash benefits to more than 3 million people many of whom are members of trade unions.[136]

The Independent Order of Odd Fellows Manchester Unity - www.oddfellows.co.uk - is a friendly society that works in partnership with the Hospital Savings Association (mentioned above). It offers sickness benefits, permanent health insurance and medical cash benefits.

Medicash - www.medicash.org.uk - is a mutual organisation that offers private health cash benefits and has many trade unionists as members. It workes particularly closely with the police and fire services and even has a formal agreement with Unison. It traditionally makes charitable donations to the NHS and has more than 230,000 workers in membership.[137]

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[135] This information is from an interview with the author in 2001.
[136] H.S.A estimate that some 30 per cent of their members are in trades unions.
[137] This is the figure for the financial year 2002-2003.

Nuffield Hospitals - www.nuffieldhospitals.org.uk - is a charitable organisation that offers a national network of 44 not-for-profit hospitals. Nuffield Hospitals Centre for Education and Clinical Effectiveness offers training to a wide range of private sector and NHS nurses, physiotherapists and other health professionals.[138] Nuffield Hospitals has close links with a wide range of worker groups and actively welcomes trade unionists into membership.

Rechabite Friendly Society - www.rechabite.co.uk - is a friendly society offering sickness benefits, permanent health insurance and private health cash benefits.

Shepherds Friendly Society - www.shepherds.co.uk - is a friendly society offering sickness benefits and permanent health insurance. It welcomes trade unionists into membership and "has links with several trade unions".[139]

Simplyhealth - www.simplyhealth.uk.com - is officially endorsed by the Trades Union Congress. It offers private medical insurance and health cash benefits to 100,000 workers. And has close and historic links to Unison and the Transport and General Workers Union.[140]

Standard Life Healthcare - www.standardlife.co.uk - is a part of the Standard Life group and therefore part of one of the Europe's wealthiest mutual organisations. Standard Life Healthcare is one of Britain's leading private medical insurers. It also works closely with the Birmingham Hospital Saturday fund which provides private health cash benefits.

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[138] Nuffield Hospitals Centre for Education and Clinical Effectiveness offers a wide range of clinical courses for healthcare staff. Through strong links with the University of Central England and Middlesex University, most of the courses are accredited with academic points at diploma, degree or Masters Level, which can aid students in pursuing Higher Education awards and career progression. These links with the Universities also facilitate developments in Evidence-Based practice and assistance in Clinical Research projects. NVQs for Theatres and Health Care Assistants in the wards are also available and have been integrated as a Skills Escalator. One of the many advantages the Centre provides is the opportunity for all students to obtain professional and academic qualifications, whilst still in full-time employment through Distance Learning and Work-based programmes. The programme managers from the Education Centre provide outreach courses in divisions, via Satellite Centres as well as in hospitals.

[139] This information is from an interview with the author in 2001.

[140] SimplyHealth was purchased by H.S.A in 2003. However, traditionally this private healthcare brand has worked closely with the former GMB Union and the TGWU. Also see: Daniel Kruger, op.cit.

Wakefield Health Scheme - www.wdhcs.com - offers private health cash benefits and has more than 50,000 workers in membership. Many of them are current or former trade unionists.[141]

Western Provident Association - www.wpa.org.uk – is a mutual organisation that offers a wide range of private medical insurance and health cash benefits.

Westfield Contributory Health Scheme - www.westfield.org.uk - offers private health cash benefits. It has many trade unionists in membership and has a particularly close relationship with members of the Transport and General Workers Union. It has more than 250,000 workers in membership and traditionally has an exhibition stand at the annual Labour Party conference.

As is clear from this list, many public sector trade unions such as Unison and the Transport and General Workers Union have formal links with private medical insurers and even private health cash schemes such as Simplyhealth and Medicash.

> "Today, independent sector not-for-profit organisations such as the Benenden Hospital, Bristol Contributory Welfare Association, BUPA, Civil Service Healthcare Society, Hospitals Savings Association, Simplyhealth, Standard Life Healthcare, Wakefield Health Scheme, Westfield Contributory Health Scheme and dozens of other similar bodies, have millions of trade unionists in their combined memberships.
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> "Many public sector trade unions such as Unison even have formal links with private health cash schemes such as Medicash and promote them on their internet sites. These schemes are an important and growing source of revenue for the independent sector and add to the diversity of the overall health market."[142]

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[141] This information is from an interview with the author in 2001.
[142] Edward Vaizey (ed) (2002) The Blue Book On Health: Radical Thinking on the Future of the NHS, London, Politicos Publishing, p.99.

According to the IHA it would require the equivalent of 4 to 5 pence in the pound on the basic rate of income tax to simply replace current private spending on independent healthcare services.[143] To fully replace the independent sector's entire contribution – including private health cash benefits and social care - would cost the exchequer much more.[144]

In the other European democracies, there is a long established recognition that partnership working is good for health and welfare services. The idea that the state should own all of a nation's health facilities is treated with derision and has remained off the political agenda. In Belgium two thirds of hospital beds are in the independent sector.[145] In Germany and Spain half the hospital beds are independent.[146] In Austria, France, Greece and Italy, more than one third of all hospital beds are in the independent sector.[147]

Perhaps it was with these facts in mind that the government entered into its agreement with the Independent Healthcare Association in the autumn of 2000 and signed the Concordat, which gave formal permission for NHS patients to be sent to independent sector hospitals.

Between 1 January and 31 August 2001, more than 65,000 NHS patients had been treated under the Concordat in independent sector hospitals. By the end of the year they had treated more than 100,000 NHS patients.[148] Overall, this level of partnership working represents a three-to-four fold increase over anything that had gone before and it continues to rise.[149]

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[143] Independent Healthcare Association Written Evidence submitted to the House of Commons Health Select Committee Inquiry into the Role of the Private Sector in the NHS, October 2001.
[144] (1994) Health 2000 The Health and Wealth of the Nation in the 21st Century: A Contribution from the Independent Healthcare Association to the Labour Party, London, Independent Healthcare Association, pp.3-4.
[145] (1993) Hospital Committee of the European Community, Hospital Services in the European Community, Leuven (Belgium), p.29.
[146] Stephen Pollard, Terry Liddle, Dr. Bill Thompson (1994) Towards a More Cooperative Society: Ideas on the Future of the British Labour Movement and Independent Healthcare, London, Independent Healthcare Association, pp.13-14.
[147] Ibid.
[148] Independent Healthcare Association information taken from monthly Concordat monitoring data supplied to the Department of Health in 2001 and seen by the author.
[149] Ibid.

In line with other European countries, NHS-funded patients are no longer confined to receiving treatment and care in state owned hospitals. Today, they are increasingly accessing hospital and care services provided in independent - charitable, mutual and commercially owned - facilities.

There are now more than 200 independent acute medical and surgical hospitals across the country. With more than 600 operating theatres, 800 critical illness beds and over 10,000 acute medical/surgical beds, their numbers and quality are impressive.[150] Delivering more than 1 million surgical procedures a year and seeing more than 4 million people in out-patient appointments the sector's hospitals offer substantial capacity to help ease pressures on the NHS.

In mental health, the Mental Health Act Commission points out that independent sector providers now deliver more than 55% of the NHS's medium secure provision.[151] Offering innovative and pioneering services in high quality surroundings, independent providers have demonstrated in recent years that partnership can work and can hugely benefit the lives of patients.[152]

Independent providers of acute mental health and substance misuse services now offer more than 70 facilities up and down the country.[153] Providing more than three thousand beds, they deliver around a quarter of the country's combined acute mental health provision.[154] Providing 31 specialist units for treating eating disorders, the sector also provides more than 80 per cent of the country's acquired brain injury rehabilitation and delivers a majority of the country's substance misuse care.[155]

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[150] Data from the Independent Healthcare Association Acute Hosptial Survey 1999-2000, London, Independent Healthcare Association.
[151] Ibid.
[152] Ibid.
[153] Ibid.
[154] Ibid.
[155] Ibid.

Independent nursing and residential care homes provide at least 420,000 beds and more than one hundred and fifty million nights of care each year. Mainly used by older people who require long or short-term care they are an integral part of the nation's wider health and social care system.[156]

Today, the independent health and social care sector is amongst the country's ten largest employers. With a workforce of more than 750,000 people it accounts for nearly 3% of the total workforce. 660,000 people work in independent social care provision, while thousands more work in its acute medical, surgical and mental health hospitals. Still more work for independent nursing agencies, pathology laboratories and a host of other health and social care companies.[157]

While it is often argued that the independent sector makes no contribution to the training and development of medical and health professionals, in reality, the evidence suggests otherwise. Today, the independent sector helps to train large number of nurses and allied health professionals by providing clinical placements, vocational qualifications to care workers and post-graduate education for doctors.[158]

In partnership with the NHS, many thousands of student nurses now spend anything up to several months at a time in independent hospitals and nursing homes where they learn about a wide range of specialities. With the sector taking a lead on care for the elderly, it offers a particular wealth of expertise in the healthcare of older people.

The independent sector offers post-graduate training for thousands of registered nurses and allied health professionals. Here, training covers theatres, neurosurgery, critical care, and cardiac, renal, infection control, risk management, care of the elderly and continence management.[159] Also supporting management training courses for nurses, the independent sector

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[156] (2000) Caring Solutions, London, Independent Healthcare Association.
[157] Ibid.
[158] Ibid.
[159] Ibid.

supports dozens of management and leadership programmes up and down the country.[160]

The independent sector helps to train post-graduate doctors. In the area of mental health, the sector offers courses and up-dates on adult psychiatry, brain injury rehabilitation, and child and adolescent care.[161] Independent acute hospitals also run accredited post-graduate study courses for thousands of doctors. Encouraging peer review, they particularly provide general practitioners with valuable up-dates.[162]

Employing many hundreds of thousands of care workers, the sector's nursing and residential care homes offer many National Vocational Qualifications for care assistants.

Arguably, the greatest myth concerning the independent sector is that it steals nurses away from the NHS.[163] Yet, in recent years less than 4% of nurses who left the NHS moved to work in the independent sector.[164] The vast majority - more than 96% - simply left nursing altogether.

Having pioneered flexible working practices for many years and now supporting return to nursing courses, staff retention levels are not only higher in the independent sector,[165] but it believes it can offer the NHS proven human resource strategies.[166] Increased career and training opportunities in the independent sector not only aid its own high standards but bolster professional's commitment to the UK's wider health and social care system.[167]

Assessing the historic re-emergence of the independent healthcare sector, Dr. Evans stated in 2002:

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[160] David Lucas (ed) (2000) Independent Perspectives on Health and Social Care, London, Independent Healthcare Association, pp.22-23.
[161] Ibid,
[162] Ibid.
[163] Caring Solutions, op.cit.
[164] Ibid.
[165] Ibid.
[166] Ibid.
[167] Ibid.

> "For the first time in the history of the NHS, the independent sector is well placed to offer the state sector one million treatments over the life of a parliament. Imagine for instance that for every working day of the year each independent hospital was asked to deliver four extra operations for the NHS. That would be an additional 1,040 operations in each hospital every year. With more than 200 hospitals in the sector, the total would be more than 200,000 episodes of care a year: more than one million over the life of a five-year parliament. If the government agrees to the independent sector building and operating some of the NHS's new fast-track surgery centres, then this number could turn out to be conservative."[168]

Significantly, it had been Tony Blair had who pointed out at a speech at the Institute of Economic Affairs on 24 May 1994 that:

> "The history of workers co-operatives, the friendly societies and the unions from which the Labour Party sprang is one of individuals coming together for self-improvement and to improve peoples potential through collective action. We need to recreate for the 21st century the civil society to which these movements gave birth".[169]

Eight years on, Dr. Evans asserted on behalf of the independent sector that:

> "Today, the NHS is slowly accepting the re-emergence of a sizeable independent sector which can complement it for capacity, services, capital and expertise. Having been born of an independent sector estate that was founded with in the establishment of St Bartholomew's Hospital in 1123, British healthcare is once again turning to the independent sector for provision and funding. With private expenditure on healthcare growing in diverse and innovative ways healthcare is slowly going back to the future.

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[168] Dr. Tim Evans in a recorded interview with the author in 2002.
[169] Tony Blair quoted in The Guardian, 25th May 1994.

"Perhaps the fact that this is continuing a pace under a Labour government should not surprise us. Just as Conservatives were trusted by the electorate in the 1980s with 'industry' so it is a Labour government that is trusted with the 'human services' of health and welfare.

"Today, politically enshrined producer capture in healthcare is giving way to a rediscovery of diverse and market based institutional arrangements – many of which reside in civil society."[170]

Mapping out the new terrain of debate, Evans continued:

"Some will see the changes now afoot as being controversial. However, such conservatives are always sceptical of change and adept at whinging about most forms of progress. Their squeals and squawks are to be expected in any open society.

"In reality, the changes now afoot in British healthcare provide unprecedented opportunities for mutuals, cooperatives and commercial enterprises alike. By encouraging a rich and diverse tapestry of various forms of non-state ownership and investment, healthcare can again be reconnected to the capital-infrastructure, professional self-esteem and consumer focus that has for so long been required."[171]

Attacking the history of the politicisation of healthcare and the failings of government interventionism, Evans continued:

"For far too long, politicians of all parties have stood in the way of investment and imposed deadening uniformities of rule that undermine experimentation and achievement. For decades, powerful interest groups have been allowed to compete with each other in healthcare for various forms of legislative favour and central direction. Instead of promoting co-operative working and patient focus the system has taken

[170] Dr. Tim Evans in a recorded interview with the author in 2002.
[171] Dr. Tim Evans in a recorded interview with the author in 2002.

the idea of the gentleman in Whitehall knowing best to absurd and murderous lengths.

"Today, we stand at the gateway of a different century. A century that will increasingly judge nationalised healthcare for being a highly elitist project which unnecessarily subjected millions of people to primitive forms of health rationing and hardship.

"As consumer expectations continue to out pace the state's capacity to satisfy demand so healthcare will continue to change. The age of utopian top-down command and control has already past and a mixed economy has taken its place."[172]

He continued with the following warning:

"Yet, even at a time when progressive politicians of all parties attempt to describe this modern era under the auspices of 'partnership' so they too will find it will not be a resting place for long.

"As consumers become ever more demanding and economically empowered so they will continue to drive forward a real and highly diverse market in health. And it is in this context that politicians will continue find themselves mere corks bobbing on a tide of history. A tide which ultimately finds them to be the problem and not the solution in peoples lives."[173]

The Political Economy of Government Failure

More than fifty years on from the inception of the NHS it is possible to judge the service by its deeds. One can scrutinise its rationing, its low levels of investment, and its inequitable and inadequate comparative results. One can profile its internal structure by class, race and gender - and one can analyse the ways in which its political masters are increasingly endeavouring to 'crisis manage' by allowing the rediscovery of various forms of private healthcare.

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[172] Dr. Tim Evans in a recorded interview with the author in 2002.
[173] Dr. Tim Evans in a recorded interview with the author in 2002.

As politicians of all parties arguably turn full circle and look to the independent sector for solutions in terms of the private finance initiative (PFI), capacity (the Concordat, independent Foundation Hospitals, private Diagnostic and Treatment Centres) and organisational ideas (public private partnerships, best value, 'earned autonomy', private management of failing NHS hospitals), one does not only find the re-emergence of the independent sector, but one quickly encounters the re-discovery of non-state self-help in important areas of healthcare funding (private medical insurance, private health cash plans, acute self-funding, private dentistry, private critical illness plans and a wide range of private alternative therapies).

In the last article he wrote for the Daily Telegraph before he died in 1996, Sir Keith Joseph argued that market based institutions in civil society should be rediscovered and applied to health and welfare. Prophetically, he wrote:

> "My own favourite strategy to give every home a stake in the economy is to allow Friendly Societies to recover much of the role they relinquished over this century. No pension fund, state or corporate, conveys a sense of ownership or participation. I believe the small mutual status of Friendly Societies helps the quality of co-operative intimacy."[174]

Six years on from this statement, Alan Milburn stated:

> "Last month, I met with the chief executives of the three star [NHS] Trusts. They had a list of further specific restrictions that they wanted to have removed from them and we are now considering how best to do so. But they also asked us to go further. If they were as good as we agreed they were, why could they not become independent not-for-

[174] Sir Keith Joseph, Why the Tories are the real party of the stakeholder, Daily Telegraph, 12 January 1996.

profit institutions with just an annual cash for performance contract and no further form of performance management from the centre?"[175]

In outlining the government's ideas for genuinely independent 'Foundation Hospitals' the then Secretary of State continued:

"The middle ground between state-run public and shareholder-led private structures is where there has been growing interest in recent years. Both the Right – through organisations like the Institute of Directors – and the Left – through the Co-operative Movement – have been examining the case for new forms of organisation such as mutuals or public interest companies..."[176]

Keith Joseph had warned of such politics emanating from New Labour back in 1996. He well understood that the race to capture such terrain was on between the two major parties. He wrote in his Daily Telegraph article:

"I wonder if the Labour Party hungry for radical ideas, might steal such notions and apply them first. I regard Frank Field MP as our most dangerous opponent as he treats liberal market ideas as serious options, and not merely as misanthropy".[177]

Capturing traditionally Conservative and classical liberal terrain in one fell swoop, Milburn concluded:

"In many other European countries there are many not-for-profit voluntary or charity-run hospitals all providing care to the public health care system. There are private sector organisations doing the same. Similar steps are already starting here. We are in negotiation with BUPA..."[178]

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[175] The Secretary of State for Health, the Rt. Hon. Alan Milburn MP, speech to New Health Network, 15 January 2002.
[176] Ibid.
[177] Sir Keith Joseph, op.cit.
[178] Rt. Hon. Alan Milburn MP, op.cit.

Clearly, the scene is now set for the gradual withdrawal of the NHS from the business of provision. Already, by 2008, the government wants between 10 and 15 per cent of all acute surgery to be delivered in independently owned facilities – with the NHS simply acting as the funder and regulator of services.[179]

Already, there are suggestions that some of these facilities (for example, the new Diagnostic and Treatment Centres) will be allowed to accept privately funded patients as well as those funded by the NHS. Perhaps in time the NHS will become simply the regulator of a new and diverse market of wholly private providers.

The idea of the NHS re-positioning itself as the regulatory overseer of a market of private providers over the next decade is plausible enough. It is also possible that the NHS might over time become the health funder of last resort; as opposed, that is, to the funder of "all medical, dental and nursing care" for "everyone – rich and poor..." as stated in the late 1940s.[180]

Nevertheless, it remains doubtful that such a world would amount to a genuine market in healthcare. What would more likely emerge would be a re-discovery of the complex medical corporatism of previous centuries. A world of private health provision and funding that is again predicated on a set of professional monopoly powers gained through legislative favour.

As in earlier eras of medical history what seems most likely is a quasi-market driven by the political economy of regulation. Not a real market based on the principles of consumer sovereignty and producer reputation.

> "In every advanced industrial society the medical profession enjoys monopoly privileges in the labour market...its practitioners are highly paid, highly respected and they enjoy a great deal of control over the

[179] The 2005 Labour Party Manifesto, London, The Labour Party.
[180] The National Health Service, leaflet sent to every home in July 1948 by the Ministry of Health.

conditions of their work, even to the point of being insulated from criticism and accountability."[181]

For all the manifest failings of the NHS and the growing acceptance of a limited range of private solutions, there is still little in pubic discourse to fundamentally challenge the statist notions that underpin professional monopoly power in health. While commentators such as Stacey describe 'the central tension' in medical professional accountability in the following terms and assert with regards to the General Medical Council (GMC):

"Individual professionals are accountable to their individual patients...a professional body is responsible for seeing that the collectivity of individual practitioners perform appropriately. That body is ultimately accountable to the state through Parliament which set it up in the first place and from which it has derived its powers. However, the GMC is independent, self-financing and constitutionally directly responsible only to the Privy Council."[182]

Few commentators challenge such illusory notions of independence. Or go on to question the fundamental nature and impact of statutory regulation and monopoly power on health.

One of the few to do so is Professor David Gladstone.[183] For him the GMC is far from being an independent regulator. Maintaining its monopoly power in statute, he argues that throughout its history it has shunned consumer control and always sought domination from within the profession as well as the wider establishment. Commenting on the organisation's structure in 1992 he noted:

"Of a total membership of 102 some 54 are doctors elected from Great Britain and Northern Ireland, 35 are medical academics appointed by Universities and Royal Colleges, and 13 are nominated by the Queen

[181] Nicky Heart (1985) The Sociology of Health and Medicine, New York, Causeway Books, p.112.
[182] Margaret Stacey (1988) The Sociology of Health and Healing, London, Unwin Hyman, p.15
[183] Dr. David Gladstone (1992) Opening Up the Medical Monopoly, London, Adam Smith Institute.

on advice of the Privy Council. Of the 13 independent members, only 9 can be said to be truly 'lay' members – mostly a mixture of MPs, JPs and lawyers. Moreover, many of the members of the GMC are sponsored by the British Medical Association (BMA), the main political lobby for both hospital doctors and general practitioners. It is hard to resist the conclusion that this 'shadowy body, autocratic and punitive...whose deeply conservative stance is increasingly out of step with the needs of patients' has become a politicised organisation designed to defend the interests of the medical profession against both public scrutiny and government interference."[184]

Gladstone spelled out the adverse impact of such arrangements in an article he wrote and published in The Times:

"...longer than necessary training, intolerable conditions for those beneath the consultant level, a system of patronage and personal recommendation for appointments, limits on the number of consultancy appointments."[185]

The idea that doctors should be accountable to their patients seems at face value to be clear. However, the 'central tension' as Stacey calls it, exists because ultimately the GMC was formed to ensure not only that the ethical standards of the profession were maintained but also that doctors should remain accountable to the state. In other words, through the Medical Act of 1858:

"...the state ratified medicine's claims to be an autonomous self-governing ethical profession".[186]

In reality, the act was the product of a highly charged and protracted political and parliamentary debate. Yet once agreed, it ultimately:

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[184] Ibid., p.7.
[185] David Gladstone, 2 March 1992, 'The Doctor's Dilemma', London, The Times.
[186] Roy Porter (1987) Disease, Medicine and Society in England 1550-1860, London, Macmillan, p.52.

> "...charged the Council to regulate the medical profession on behalf of the state, to oversee medical education and to maintain a register of qualified medical practitioners."[187]

Central to this process and the GMC's remit of professional control, is its register.

> "The significance of the register lay, of course, in those it excluded. For all ranks of regular practitioners now appeared as "insiders" lined up against all "outsiders" the unqualified homeopaths, medical botanists, quacks, bone-setters and the like, who are automatically constituted by exclusion, into the "fringe". Parliament had achieved what the doctors never could; it had – symbolically at least – united the much divided medical profession, by defining them over and against a common Other."[188]

In 1975, the Merrison Report again pointed out the significance of the GMC's power and in particular its register. It commented:

> "...the body maintaining the Register has...two duties to discharge. First, it will have to assure itself that those admitted to the register are competent. Secondly, it will have to remove those practitioners unfit to practice."[189]

Of the GMC's two main functions, it is the second that is perhaps the better known; that is, its ability to remove those practitioners deemed unfit to practice. The criteria it operates to assess unprofessional conduct were up-dated in 1983 and defined as:

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[187] Stacey, op.cit., p.85.
[188] Porter, op.cit., p.52.
[189] Report of the committee of Inquiry into the Regulation of the Medical Profession (1978) HMSO, p.3.

"(a) Neglect or disregard by doctors of their professional responsibilities to patients for their care and treatment.

"(b) Abuse of professional privileges or skills

"(c) Personal behaviour: conduct derogatory to the reputation of the medical profession.

"(d) Advertising, canvassing and related professional offences."[190]

In more recent years however, commentators have increasingly argued that the GMC has systematically failed in its responsibility to the public interest not least because it has been seemingly incapable of tackling even less serious offences. As one article in the British Medical Journal stated:

"There is a long standing unhappiness with the council's seeming inability to respond to doctors who are incompetent or rude but who have not been guilty of acts which the council would judge to be serious professional misconduct."[191]

Whilst the GMC is not formally responsible for the supply of medical education, nor has formal control over the number of people who may train, the supervision of medical education is nevertheless one of the principal tasks Parliament assigned to it. It not only has a role in the content of the medical curriculum, but more importantly offers legitimacy to those who have qualified.

The nature of the information contained on the Register – and therefore of medical training and professional qualification – has been the subject of prolonged debate and legal action over the years. For example, in 1968 the Todd Report on Medical Education recommended that the GMC registered individual's specialisations in addition to basic medical qualification.[192]

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[190] General Medical Council (1983) Professional Conduct and Discipline: Fitness to Practice.
[191] British Medical Journal, editorial, 15 May 1992.
[192] Royal Commission on Medical Education (1968) HMSO.

In the 1990s, the related issues of registration and accreditation and the nature of consultants and specialists became the subject of legal action in the name of Dr. Anthony Goldstein.[193] One aspect of this case brought against the GMC was that the information it provided on its Medical Register did not enable the public to distinguish between doctors who have completed an appropriate training programme based on supervised clinical experience and those who have spent the major part of their training period in research and academic work therefore have little if any clinical responsibility.

Another element of the case related to European Community law. For it was argued that the GMC acted both unfairly and in a discriminatory manner in relation to the system of specialist medical training and the appointment of UK consultants.

In 1975 a European Community Medical Directive governing the mutual recognition of qualifications was passed which then came into force in 1977. It was designed to ensure that fully qualified doctors, whether general practitioners or specialists, could practice anywhere in the European Community – including Britain.

However, in spite of the introduction of European certificates of specialist training, British health employers continued to place a much greater emphasis on the UK certificate of specialist accreditation awarded by the Royal Colleges. As Gladstone noted in 1992:

> "Under GMC rules only those doctors who hold a certificate of UK accreditation – granted by the respective Royal Colleges Joint Committee on specialist training – can have the designation 'T' after their name in the Medical Register."[194]

However, as is pointed out in a GMC footnote:

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[193] See Gladstone, op.cit, p.9.
[194] Ibid., pp.9-10.

> "A doctor who has completed the training required for independent medical practice in his or her speciality i.e. for appointment to a consultant post within the National Health Service or as a principal in general practice, is eligible to apply to have an indicator "T" to this effect included in his or her entry."[195]

In contrast to this the names of those practitioners who hold the European certificate are not mentioned in the Medical Register at all. Instead, the details of those who hold the certificate are – according to GMC Standing Orders - held on cards:

> "...kept in [a] metal cabinet...locked when it is not in use. Only the Registrar shall have access to the cabinet."[196]

For Gladstone, it is clear that the GMC has actively withheld information from the public concerning the specialists who are qualified by means of the European certificate. Commenting on this highly restrictive practice he asserts:

> "In withholding such information how far is the GMC acting in 'the public interest' either of patients or of health care planning? Or conversely, how far is it seeking to uphold a discriminatory system which perpetuates the status quo of British medical training and hospital practice by restricting the numbers eligible for consultant status?"[197]

He concludes:

> "There can be little doubt that publication of the full Specialist List would signal a revolution in British health care, not only by increasing

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[195] Ibid., p.10.
[196] Ibid.
[197] Ibid.

> the number of specialists but also, potentially, in reducing waiting times and lists and offering patients an alterative and direct route into specialist services.[198]

According to Isobel Allen the medical monopoly rests on a system which is perpetuated by patronage and by personal recommendation and selection up the up-coming generation. These factors encourage a conservatism in the medical profession which demands that academic, intellectual and clinical excellence are insufficient in and of themselves for a career at the top of hospital medicine.[199]

Allen's study was based on interviews with 640 doctors throughout Great Britain who had qualified in 1966, 1976 and 1981. Not only does it describe the disillusionment that many doctors felt with their careers but it also indicated the role which personal recommendation plays in the system of medical promotion and preferment. Contrary to her belief before carrying out the study that "very personal patronage might be dying out"[200] her interviews indicated its persistent importance.

In fact, significantly, whereas 31 per cent of both the 1966 and 1976 qualifiers thought that patrons or sponsors were very important, 52 per cent of the 1981 qualifiers did so.[201]

The research demonstrated that patrons tended to be male consultants, a fact which, Allen points out, may disadvantage women and reinforce the male 'stranglehold' in certain areas of medical practice. A 1981 qualifier in her sample, for example, pointed out that of the highly competitive specialities:

> "...it's inevitable it will be men that are favoured because the set up is ultra conservative and self-perpetuating."[202]

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[198] Ibid.
[199] Isobel Allen (1988) Doctors and their Careers, Policy Studies Institute, p.153.
[200] Ibid., pp.153-154.
[201] Ibid.
[202] Ibid., p.167.

One woman consultant, who she interviewed also reported that:

> "They appoint not necessarily the best but the one who's not going to rock the boat...I've seen a number of very bright people whose face and personality don't fit and who were out...It's such a small world – so enclosed – you've got to be able to work together. I can see how the system has evolved. It's self-preservation."[203]

In open markets, the threat of entry by newcomers not only puts pressure on prices, but it also acts as a pressure towards innovation and the discovery of optimal outcomes. In monopolies, however, resistance to innovation is strong. Unchallenged professional conservatism and a resistance to change becomes the dominant ethos.

It is ironic that after more than half a century of the NHS, and several hundred years of politicians bestowing monopoly powers on medical professionals, it is governmental failure in health systems that can be argued to cause precisely those problems most popularly associated with notions of 'market failure'.

After centuries of politicised healthcare and decades of full blown health nationalisation the resultant and statist problems of monopoly, consumer ignorance, neglect of the poor and sick, lack of provision, and moral hazard are clear for all to see. Externalities that in a de-politicised world would be internalised by market processes remain problematic. Devoid of rational market price signals, the misallocated resources of political-economy remain largely unaccounted for.

Indeed, given the weight of evidence why is the dominant paradigm of market failure still so prevalent amongst health opinion formers and not 'government failure'? Below the popular rubrics of equality, altruism and even 'public sector ethos' what do health opinion formers - in academia, government and the media – really think about the political economy of healthcare? When it

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[203] Ibid., pp.162-163.

comes to notions of government failure in health economics what are the boundaries, background and subtext of their thinking?

CHAPTER V

THE METHODOLOGY OF AN INQUIRY INTO NOTIONS OF MARKET FAILURE AMONGST BRITISH HEALTH CARE OPINION FORMERS

This chapter is concerned with the methodology of an investigation that explores and questions notions of market failure in modern health policy, economics and popular discourse. As such, it is primarily concerned with the methodological foundations of empirical research into the opinions of British health opinion formers - journalists, academics, politicians, government officials and members of interest groups.

Opinion Formation

It was Nigel Lawson who in 1992 stated:

> "The National Health Service is the closest thing the English have to a religion, with those who practise in it regarding themselves as a priesthood."[1]

In many ways, it is surprising that the NHS remains one of post-war Britain's most durable and popular institutions. For as Roderick Nye of the Social Market Foundation has commented:

> "At heart [the NHS] has a mission to disappoint: by rationing health care to individuals so that it is available to all on the basis of need. That it has succeeded in this while retaining popular affection is a mark of just how profound the fact of the NHS's existence has been in managing people's expectations."[2]

While it is always difficult to prove a causal relationship between opinion formers such as journalists, academics, politicians, government officials,

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[1] Nigel Lawson, (1992) The View from Number Eleven, Doubleday, London.
[2] Roderick Nye in Bosanquet, N., and Pollard, S., (1997) Ready for Treatment: Popular Expectations and the Future of Health Care, Social Market Foundation, London, p. vii.

members of interest groups, and the widely held beliefs of ordinary citizens, there nevertheless does exist in society views that are popular and widespread – at any point in time.

In many instances, the job of the social scientist is to examine such beliefs, and to provide more powerful explanations of their nature and boundaries than would otherwise be afforded from everyday, commonsense, interpretation.

As such, this study is concerned with those leading opinion formers who interpret, guide and report on the NHS on a day-to-day basis. In exploring their understanding of health economics and such notions as market failure, government failure and market success, the limits and boundaries of current discourse can be identified, clarified and ultimately challenged.

In Britain today, journalists, academics, politicians, government officials, and members of health interest groups hold substantial power and influence over the way health policy and delivery are reported and discussed.

The Media

The British national press is one of the most pervasive in the world, attracting a comparatively high percentage of readers. It boasts no less than twenty (general) daily and Sunday titles[3] and, in the year 2000, just five groups controlled over four-fifths of national circulation.[4] Remarkably:

> "No new national newspaper launched in the last eighty years has been able to stay independent."[5]

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[3] This excludes the Sport, Sunday Sport and Sunday Business on the grounds that they are specialist publications. This figure also excludes the Morning Star because it is rarely stocked by newsagents and is therefore not nationally available.
[4] Curran, J., (2002) Media and Power, Routledge, London, P. 231.
[5] Ibid.

Journalists in the national press, and on television and radio, have an enormous role to play when it comes to the articulation of health policy options and wider public opinion. For some authors power relations in a liberal corporatist society mean that:

> "...a consensus is formed through consultation between government and organized interests. The system is 'liberal' in the sense that political parties tend to alternate, the armed forces are firmly under the control of civil authority and freedoms are not undermined by coercive measures. But within this system, the consensus of society tends to be defined by the major players..."[6]

For Curran and Seaton, the British national press puts forward a relatively narrow and an essentially corporatist view of the world. They comment:

> "The national press has reproduced a remarkably narrow arc of opinion, indeed sometimes only one opinion, in its editorials on a range of issues."[7]

Whereas liberal orthodoxy portrays the media as reflecting and serving society, and its more radical, Marxian, counterparts maintain that the media are implicated in the management of society, this study remains essentially neutral on such questions of societal power. It is simply not within the purview of this study to examine power relations between the organised media, ordinary people in society and their complex interactions.

Whether the media reflects or manages public opinion on health issues is, in many ways, irrelevant for the purposes of this study. What matters instead are the nature, profile and boundaries of the dominant worldview. That is, the widely held views and beliefs of opinion formers on the problems and possibilities for health policy - and health delivery.

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[6] Ibid., pp. 231-232.
[7] See: Curran. J., and Seaton, J., (1997) Power Without Responsibility: The Press and Broadcasting in Britain, 5th edition, London, Routledge.

Academia

Today in Britain there are more than 2,800 higher education courses offered in more than 150 universities, colleges, institutes and conservatoires.[8] More than 40 per cent of school leavers now continue on into higher education - and by 2010 the government wants more than 50 per cent of school leavers to participate in degree courses.[9]

Dr. Madsen Pirie of the Adam Smith Institute suggests that the impact that these institutions and courses have on students and wider opinion is not to be underestimated:

> "...You pack up for life while you are at university or college and the goods you take on board have to sustain you through the journey. Very few people make major intellectual changes during the course of their adult lives, so obviously what is done in the universities is very important for the future..."[10]

Similarly, Dennis O'Keeffe and David Marsland conclude their work, *Independence or Stagnation? The Imperatives of University Reform in the United Kingdom*:

> "British higher education is by far the most promising place to begin the course of necessary economic and intellectual correction."[11]

The Power of Government

In 2003, the British government accounted for nearly 40 per cent of Gross Domestic Product (GDP). In total, government spending amounted to £456

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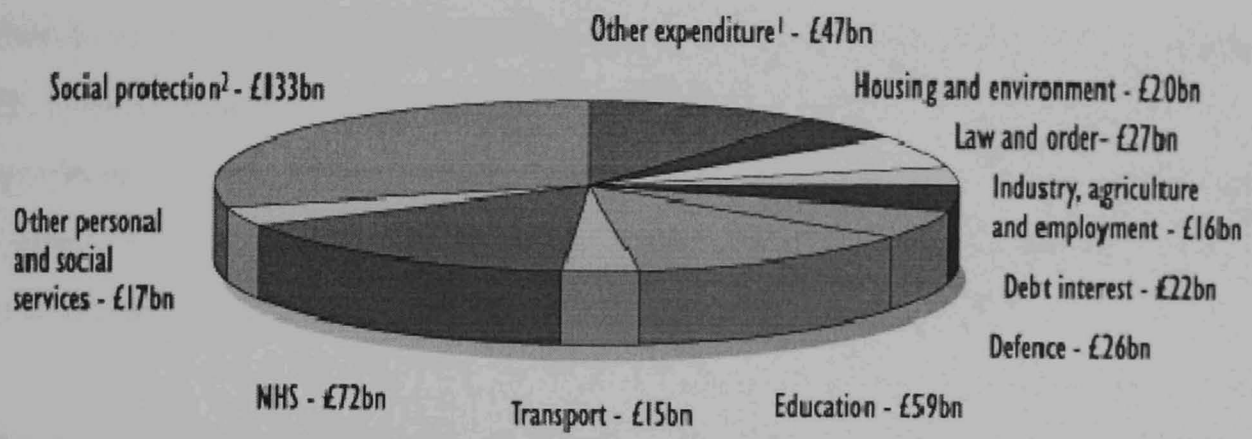
[8] Lee Elliot Major, 'Armed with the Facts', The Guardian, 28 May 2002.
[9] Polly Curtis, 'University applications recover from slump', The Guardian, 18 July 2003.
[10] Dr. Madsen Pirie in a tape recorded interview.
[11] O'Keefe, D., and Marsland, D., (2003) Independence or Stagnation? The Imperatives of University Reform in the United Kingdom, CIVITAS, London, p. 63.

billion – or £7,700 for every man, woman and child.[12] According to HM Treasury the global figure of government expenditure is rose to £485 billion in 2004-05 and again to £517 billion in 2005-06.

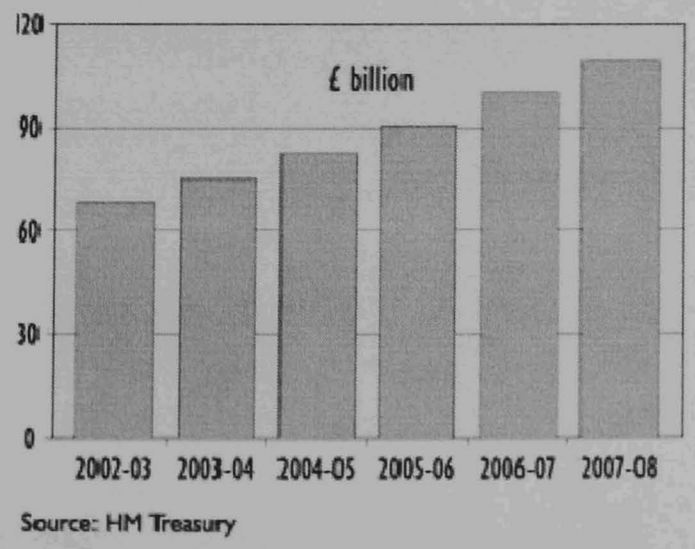
Expenditure on the NHS and personal social services accounts for a sizeable share of planned government expenditure. In 2003-04, the government spend on the NHS was £72 billion, with another £17 billion detailed for personal social services (Figure 3).



Source: HM Treasury

Figure 3. UK public expenditure by department of state 2003-2004.

Back in 2002, the government announced plans for UK spending on health to rise by 7.2 percent in real terms up to the year 2007-08.[13] This means that by 2007-08 the government expects spending on health to be more than £110 billion pounds (Figure 4).[14]



Source: HM Treasury

Figure 4. UK state expenditure on health 2002-2008.

[12] HM Treasury 2003 Budget Summary.
[13] HM Treasury, 2002 Chancellor's Budget.
[14] HM Treasury, 2003 Budget Summary.
[15] Bell, D., (1976) The Coming of Post Industrial Society, New York, Basic Books.

The NHS, personal social services and the Department of Health employs more than one million people. Many tens of thousands more work in a wide range of other health interests closely aligned to the state. These groups include such organisations as the Health and Safety Executive (HSE), Action on Smoking and Health (ASH), and the medical Royal Colleges. All receive state funding, or legislative favour – or both.

The New Class Health Nexus

In many ways today's senior managers in and around the state's health nexus hold characteristics and qualities similar to those first identified by the proponents of New Class theory. Although far broader in scope than health, the idea of a New Class was originally put forward by Daniel Bell in his book *The Coming of the Post-Industrial Society.*[15]

Bell essentially argued that developed nations were on the verge of a post-industrial society in which the production and distribution of knowledge would replace the production and distribution of goods as the dominant activity of society:

> "Just as the business firm was the key institution of the past hundred years because of its role in organising production for the mass creation of products, the university will become the central institution of the next hundred years because of its role as the new source of innovation and knowledge."[16]

At its heart, the New Class has three common features, as Nigel Ashford has commented:

> "Firstly, they belong to a common occupational strata, related to knowledge and ideas. Secondly, they share a set of common values,

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[16] Ibid., p. 343.

towards economics, politics and culture. Thirdly, they have a common interest in an expanding public sector."[17]

It was Joseph Schumpeter who argued that intellectuals:

> "...develop group attitudes and group interests sufficiently strong to make large numbers of them behave in a way that is usually associated with the concept of social classes."[18]

Schumpeter suggested that the intelligentsia are hostile to free market capitalism because:

> "It lives on criticism and its whole position depends on criticism that stings".[19]

For Irving Kristol, members of the New Class can be found in a detailed and specific list. They include:

> "Scientists, teachers and educational administrators, journalists and others in the communications industries, psychologists, social workers, those lawyers and doctors who make their careers in the expanding public sector, city planners, the staffs of large foundations, the upper level of the government bureaucracy and so on."[20]

To proponents of New Class theory, its most important members are academics, for they act as the prime legitimators of society. Academics have great power because of their direct contact with students, and because they produce ideas consumed by other members of the New Class. Importantly, academics act as a reference group for the other elements within the New Class who do not have the time or facility to develop their own ideas.

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[17] Ashford, N., (1986) Neo-Conservatism and the New Class: A Critical Evaluation, Sociological Notes No.3., London, Libertarian Alliance, p.2.
[18] Schumpeter, J., (1942) Capitalism, Socialism and Democracy, London, Allen & Unwin, p. 134.
[19] Ibid.
[20] Kristol, I (1978) Two Cheers for Capitalism, New York, Basic Books, p. 27.

In the 1970s, Lipset found that a positive incidence of leftism was associated with being an academic professor, and in particular a social scientist. Professors and university lecturers were far more likely to describe themselves as liberal (in the American sense) or radical than any other group in society. Social scientists, with their potential for a more direct impact on public policy, were more leftwing and statist than other disciplines.[21]

Similarly, David Marsland argued in his book *Seeds of Bankruptcy: Sociological Bias Against Business and Freedom*, that British sociology and its practitioners in the main have been captured by a statist, anti-enterprise, anti-freedom mindset.[22]

Another major group employed in the New Class are those involved in journalism. In recent decades the media – newspapers, television and radio – have changed significantly. Journalism has changed from being a relatively low status, working class profession to one with high status, salaries and attractive to the upper middle class.

Today, an overwhelming majority of journalists are university graduates. As a result of their education - and their desire to achieve and sustain their high status - they look to academics as an important reference group:

> "So that comments from academics are almost obligatory in the quality newspapers and magazines".[23]

Andrew Greely attributed the feeling in the mass media to the psychology of guilt:

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[21] In the US context, 76 per cent voted for George McGovern as President and 64 per cent identified themselves as being liberal or very liberal.

[22] Marsland, D., (1988) Seeds of Bankruptcy: Sociological Bias Against Business and Freedom, Claridge Press, London.

[23] Ladd., E. C and Lipset, S., (1975) The Divided Academy, New York, Norton. Lipset, S., and Dobson, R (1972) 'The Intellectual as Critic and Rebel', Daedalus Vol.101, No. 3, pp 211-289.

> "...vis-à-vis the full-fledged academic, who presumably knows more and is more morally pure than the media huckster".[24]

Members of the New Class are also found among government officials, public sector employees (such as school teachers and social workers) and in key professions such as law and medicine. The New Class thus represents a substantial number of people in modern Britain, and across the West. But even more important than their numbers is their position in the strategically important sectors of modern society.

In the economic sphere the New Class is thought to be essentially socialist. Not in terms of formally advocating the state ownership of the means of production, but in its concerns with the distribution of income and wealth arising from the market. Ashford explains it in the following terms:

> "The New Class want the distribution of income to be determined by the principle of social justice, which means by their contribution to society determined collectively. However, such a position assumes that someone knows what is socially just, and has the authority to distribute income on those principles. Distribution would be determined by the state, over which the New Class has so much influence, rather than the market, where there are only a minority of consumers."[25]

Similarly, Irving Kristol has commented:

> "There is a class of people who believe that they can define 'social justice', that they have an authoritative conception of the common good that should be imposed on society by using the force of government. These people can be called the New Class."[26]

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[24] Greely, A., (1974) Building Coalitions, New York, New Viewpoints, p. 259.
[25] Ashford, N., op.cit., p. 4.
[26] Kristol, I., (1978) Two Cheers for Capitalism, New York, Basic Books, p. 67

Whilst an open society is arguably one without a consensus on the common good and without a single authority that proclaims its access to the 'truth' on such matters, the New Class thinks otherwise – or at least proclaims to.

For even in its circles there is no fundamental agreement on the distribution that should arise from social justice. As Kristol points out, despite frequent requests to publish an article describing the proper redistribution of income:

> "...despite all the talk 'about equality', no one seems willing to commit himself to a precise definition".[27]

For Ashford:

> "Equality is but a surrogate term for the demand for the collective distribution of income rather than for any particular distribution...The New Class lack a clear conception of an egalitarian society, and certainly do not have an agreed conception."[28]

Arguably, New Class ideas on economics can be best seen in attitudes towards the distribution of health care and other welfare services. Moynihan complained that his proposals for a guaranteed family income were frustrated by the New Class of service-dispensers, who preferred a service strategy by which middle class professionals would be employed to provide the services, rather than an income strategy by which the poor can purchase their own requirements.

He quoted extensively from Samuel Gompers, one of the founding fathers of the American trade union movement:

> "They want to do good in the world – the majority, in truth, that they may feel that flow of gratification that comes from doing for others. They have a vision of a new world with themselves as creators...they

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[27] Ibid., p. 127.
[28] Ashford, N., op.cit., p. 4.

> are experts in social welfare, domestic relations, child life, and the thousand and one problems that arise out of the lives of the poor...All these solutions are formulated along the lines that necessitate governmental machinery and the employment of experts – the 'intellectuals'. The conclusion is inevitable that there is a very close connection between employment as experts and the enthusiasm for human welfare."[29]

Arguably, one key source of power for the New Class is the weakness and a lack of opposition to its ideas. One possible source of opposition might come from the business community. Indeed, Kirstol argues that there is a form of class war being waged between the New Class and those in business. However, the latter lack an appropriate response and strategy because they simply do not possess the necessary political and tactical skills to challenge the new class.[30]

Increasing acceptance of concepts such as corporate social responsibility[31] undermines the proft-maximising and wealth creating function of business in favour of a responsibility that instead can be directed and manipulated by members of the New Class:

> "The relative weakness of the business class in the field of ideas and symbols, as compared with the massive strength of the New Class in precisely these areas, has significantly altered the power relationship between the two elites."[32]

To Lipset, the working class are viewed as the natural allies of business as part of a coalition for growth and as a defender of private sector values.[33] Ladd and Hadley demonstrated that in contrast to the essentially upper middle

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[29] Moynihan, D. P., (1973) The Politics of a Guaranteed Income, New York, Random House, p. 305. Moynihan, D. P., (1975) Coping, New York, Random House, p. 381.
[30] Kristol, I., (1978) op.cit. Also see: Bruce-Riggs, M., (ed) (1979) The New Class, New Brunsick, New Jersey, Transaction Books, Chapter 5.
[31] Ashford, N., op.cit., p. 7.
[32] Novak, (1978) The American Vision, Washington DC, American Enterprise Institute, p. 34.
[33] Lipset, S., (1978) op.cit., Chapter 13.

class values stressing non-materialist satisfactions, self-fulfilment, and big government expenditure, the working class believe in hard work, economic security, and lower taxes.[34]

Given such evidence, it is at least plausible that the leading opinion formers in the worlds of British health journalism, academia, politics, government, and interest groups will have a disproportionately high impact on the way the NHS, healthcare and health policy are thought about in wider society.

In exploring their understanding of health economics and such notions as market failure, government failure and market success, one should be able to highlight and examine some of the limits, boundaries and biases of popular discourse – and opinion.

Public Health and Public Opinion

Aneurin Bevan's declared aim, when he established the NHS was to 'universalise the best'. However, as Nick Bosanquet and Stephen Pollard have suggested:

> "..rather than universalising the best, its proudest boast should be that it has universalised the adequate. To ensure that everyone receives the best conceivable treatment has always been beyond even the generous financing the service has received over the past 49 years. The story of the NHS so far, which will characterise health care into the next century, has instead been one of rationing scarce resources."[35]

Given this reality of experience, Bosanquet and Pollard commissioned a survey of public opinion by MORI during August 1997.[36] The survey sought to

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[34] Ladd, E. C., and Hadley, C., (1978) Transformations of the American Party System New York, Norton, 2nd Edition.
[35] Bosanquet, N., and Pollard, S., (1997) Ready for Treatment: Popular Expectations and the Future of Health Care, London, Social Market Foundation, p. 1.
[36] Ibid., p. 39.

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[36] Ibid., p. 39.

explore in detail not just what people wanted from the NHS but, over the next ten years, what they expected.

Using a series of half hour, one-to-one interviews the research produced represented the most extensive survey undertaken into the attitude of the British public on the NHS. A total of 2,012 interviews were conducted face-to-face, in-house, among adults aged 15 and over. The research was carried out between July 12th and August 3rd 1997 across Britain. Quotas were set for sex, age and working status, and the data that resulted was weighted to the known population profile.

Almost two-thirds (64 per cent) of respondents said that they believe that people often make unnecessary visits to their GP because the service costs nothing at the point of use. Moreover:

> "One in five (19 per cent) believe strongly that this is the case and one-quarter disagree (although only 6 per cent disagree strongly). DEs are more inclined than ABs to think that people make unnecessary visits.
>
> "Fewer, albeit a substantial minority (35 per cent), think that people go so far as to neglect their health because the NHS is there to pick up the pieces. More (45 per cent) feel that such behaviour does not exist. Again, DEs are more cynical than ABs in this respect."[37]

Asked to say from a list of three possibilities how the NHS should be funded, most (55 per cent) at that time opted for increasing taxes. 20 per cent favoured maintaining current levels of taxation but increasing the level of rationing. Slightly fewer (16 per cent) say they would favour cutting taxes while encouraging individuals to take out private medical insurance.[38]

Significantly, the study found that:

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[37] Ibid., pp. 42-43.
[38] Ibid., pp. 48-49.

> "Those especially likely to favour the introduction of rationing in return for no increase in taxation are those from the lowest social classes and aged under 25 (36 per cent), and those aged over 25 who are frequent users of health services (29 per cent). Conversely, few ABC1s aged 35+ feel that this would be the best way forward (11 per cent)."[39]

Two-thirds of respondents (65 per cent) say that a health service paid for by taxes should be free at the point of use for everyone. Almost one in five (17 per cent) feel that the NHS should charge everyone, except those most in need. And a similar number (16 per cent) are in favour of a sliding scale of charges based on income.

> "Asked, which of these three options is most likely to exist in the Britain of 2007, the majority of adults feel some kind of payment will be required. A mere one in eight (13 per cent) envisage that a service that is free at the point of delivery, much like the NHS of today, will still be in place."[40]

When it comes to rationing:

> "Two thirds (67 per cent) of adults think that the NHS of 2007 will provide fewer services than the NHS of today and that certain services will only be available privately. Far fewer think this scenario unlikely (18 per cent), and 14 per cent have no strong opinion either way. The very old and the very young are among the least inclined to think that the NHS will not provide as many services in ten years' time, although even among these groups the majority anticipate reduced provision."[41]

The evaluation of the data continues:

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[39] Ibid., p. 48.
[40] Ibid., p. 54-55.
[41] Ibid., p. 54.

> "This shows the disparity between expectations and desire, and, arguably, between reality and wishes. Although widely expected, such a change would clearly be unpopular. Four out of five adults say they would oppose a reduction in the number of services provided by the NHS, compared with just one-tenth who would be supportive."[42]

As well as expecting fewer services to be available, the public also expects to see an increase in service rationing. In total, three-quarters (76 per cent) of adults believe the amount of prioritising will have increased in a decade. Just one-tenth expect the opposite.

> "People in the age range 25-44, ABs and those paying tax at the highest rates (groups among whom there is a considerable overlap) are particularly inclined to feel that the degree of rationing will escalate....Younger people, and those under 25 especially, are more likely to be in favour of such a change than their older counterparts (especially those aged 45-55). However, in no age (or indeed any other) group does the proportion who support an increase in rationing come close to the proportion who oppose it."[43]

Most (62 per cent) adults think that NHS services will no longer be free at the point of use by the year 2007. Here:

> "Age has a marked impact on perception. Young people (15-24) are much more likely than older people (55+) to expect that payment will be required for NHS services...Clearly, such expectation is not based on public longing. The vast majority (four in five) oppose the principle of paying to use NHS services. By contrast, just one in eight (12 per cent) are supportive (a mere 1 per cent strongly so)."[44]

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[42] Ibid.
[43] Ibid., p. 56.
[44] Ibid., p. 64.

Respondents widely anticipate that the proportion of individuals with private medical insurance (PMI) will be greater in ten years' time that it is now.

> "Eight in ten expect to see an increase in the proportion of individuals who have voluntarily taken out PMI, compared with just 8 per cent who think that an increase is unlikely. A clear majority (70 per cent) believe that PMI paid for by individuals will be obligatory by 2007, and only one in five think that this is unlikely. Half envisage that PMI paid for by employers will be compulsory in ten years' time, and one-third think the opposite."[45]

Some 53 per cent of respondents say they would support an increase in the proportion of adults voluntarily taking out PMI, and 18 per cent say they would be opposed. Again:

> "More people feel that individuals should be able to decide the amount they spend on PMI than feel that a compulsory minimum should be set by the government. Asked to imagine that free health care was available only to those with lower incomes and that taxes were reduced to enable those not eligible to take out PMI, more than two in five (45 percent) say that individuals should be free to decide how much they spend on PMI.
>
> "Just one-quarter think that a compulsory minimum should be set, and three in ten feel unable to decide."[46]

When it comes to the questions of quality of treatment:

> "Opinion is divided over whether the quality of treatment offered by the NHS in any way differs from the quality of treatment provided by private suppliers. Four in ten think that the two services are about

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[45] Ibid., p. 84.
[46] Ibid., p. 88.

equal, three in ten think that private care has the edge, and one in ten perceive the NHS to be superior."[47]

However, again, age has a considerable impact on perception. Younger people are much more likely to be advocates of private treatment than their older counterparts.

"For example, among the under 25s, 8 per cent say they consider the NHS to offer a better quality of service and 46 per cent say the same about private care. Among the over 65s, the corresponding figures are 17 per cent and 18 per cent respectively. By social class, C2s emerge as the most positive about the quality of private treatment."[48]

Here political affiliation has comparatively little impact on opinion.

"Although current Labour supporters are slightly more likely than Conservatives to think that NHS treatment is better, as many Labour supporters as Tories say that the quality of private health care is best."[49]

Overall, the implications of this ground breaking research are clear. As Bosanquet and Pollard conclude:

"The summary indicates that the public is beginning to accept that change is inevitable. Some groups appear more receptive to change than others, implying that they may be willing to consider yet more reform, or that they may serve to influence other elements of society. However, it should be appreciated that (in most cases) only a minority in each group actively welcomes reform."[50]

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[47] Ibid., p. 90.
[48] Ibid.
[49] Ibid.
[50] Ibid., p. 93.

Although public opinion is today evidently in a very different world to that into which the NHS was born, the MORI research clearly indicates a central contradiction in popular perception.

> "The most striking general finding of the survey is the gap between expectations and wants. Broadly, the public wants the NHS to offer everything, and to offer it free; 65 per cent say, for instance, the NHS services would always be free. But, crucially, a mere 13 per cent except that they will be free in ten years' time. Some 67 per cent think that the NHS will provide fewer services and that those no longer covered will only be available privately, even though 80 per cent do not like such a prospect.
>
> "It is on this expectations gap that modernisers should focus. With expectations so clearly dampened, the battle is half way won."[51]

Researching Limits, Boundaries and Bias

The research outlined above was conduced only weeks after Prime Minister Tony Blair arrived into office in 1997. Since then it could be argued that his government has exploited the public's 'dampened expectations' on health and, as such, his minister's have been able to move forward with an essentially modernising agenda.

As was stated in Chapter IV, acceptance of the private finance initiative, public private partnerships, the 2000 Concordat with independent hospitals, the arrival of independent not-for-profit Foundation Trusts, and even more recently, privately designed, built, financed and operated Diagnostic and Treatment Centres – all conspire to suggest a government at ease with major elements of market-inclined reform.

Today, the political class are leaving the NHS's vision and promises of the 1940s behind. Instead of seeing the service in its fully nationalised format,

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[51] Ibid., pp. 98-99.

politicians are busy recasting it as a regulator and a funder of healthcare – but not the owner or manager of the facilities in which healthcare is actually delivered.

Similarly, whilst they see the NHS remaining as a key funder of healthcare they ultimately only see it as one of a number. With millions of people already covered by private medical insurance, private cash plans or willing to self-fund, it is perhaps no surprise that even back in 1997, 53 per cent of respondents said they would support an increase in the proportion of adults voluntarily taking out private health cover.[52]

Nevertheless, even with major elements of British state healthcare returning to some semblance of private ownership, this does not necessarily mean that anything like a genuinely free market is becoming accepted by opinion formers or the electorate.

For as was stated earlier on in this study, ever since Roman times, political elites in Britain have always sought to plan, control and regulate the provision of health services. Through the military, the church, the Royal Colleges, Parliament, and the timeless granting of legislative favour, the state has always sought to empire-build and to control people's access to healthcare and medicine.

Far from operating in a real market, healthcare as always been a highly politicised and controlled activity: one that rests on a large measure of coercion and governmental license.

As such, the principles of a genuine market order have never been applied to this most important area of human progress and achievement. In this context, the way that the language of the market is often applied to the analysis of health policy is itself a highly questionable and potentially damaging practice. For if the language and notions of the market are imputed to describe what

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[52] Ibid., p. 88.

are in reality identified problems that have more to do with state interventionism and government failure, the entire debate becomes set on a highly confused and ultimately meaningless linguistic foundation.

Given that health is in reality one of the most politicised areas of human activity, and that the linguistic limits placed on its discourse require a sound degree of objectivity, it is potentially disquieting if the boundaries set, place a bias that precludes viable and sustained reasoning.

If the language and phraseology of the market are invoked, yet the structures, incentives and reality of healthcare remain essentially statist, public discourse runs the risk of being bound by an unintelligible world of economic and legal relativism.

On the popular question of externalities for instance, whilst the genuine free marketer might seek reform by the internalisation of externalities, the unintelligible relativist might genuinely believe that externalities are an inevitable outcome of what is already popularly accepted as a market.

To put it another way: if a market is not rigorously adhered to in terms of such operational definitions as private property rights, the rule of law and market driven reputation then it cannot be said in any meaningful sense to be a genuine market.

If a General Medical Council, a Royal College or a private company are granted legislative favour by the state, then they can no longer be said to be *of the market* in any objective and meaningful sense.

As the foundations of western society and prosperity – private property rights, the rule of law, and market-driven reputation – are not popularly articulated or understood. The often confused and arbitrary language that overlays public debate therefore suggests that from our ignorance adverse social power relations are born.

For arguably in a genuine market the providers of health would have to surcome to the rigours of the consumer's power and the levelling principles of arbitrage. Could it be that the reason why professional groups receive more than 40 per cent more NHS spending per illness episode than those on lower incomes is not – in causal terms - because the middle classes are better at asserting their rights, but instead because such built-in inequity is the inevitable product of the political economy of legislative favour and producer capture?

It is not within the purview or range of this study to answer such an important, and complex, question. Suffice to say, the task in hand here is much simpler. This study is seeking to find how British opinion formers, at the beginning of the twenty first century, think about markets in health and to what extent they adhere to a rigorous and logical analysis?

When a representative sample of leading health opinion formers – journalists, academics, politicians, government officials and members of relevant interest groups – think about 'a free market in health', what meaning does such a notion have for them? What is their perspective on what a market in health is, or could-be?

Ultimately, in surveying respondents views and assessing relevant commonalities and cleavages in their attitudes, the study is able to profile and assess the limits, boundaries and biases of this influential group's beliefs and suppositions.

Methodology and Inquiry

Given the historic evidence presented in the previous chapters of this study, and the argument that British healthcare has always been highly politicised, it is at least plausible to imagine that under analysis leading opinion formers will find it difficult to articulate or even comprehend a market in health without invoking populist notions of market failure.

For as David Green has suggested:

> "The dominant academic view is that attempts by ordinary people to obtain health care for themselves, without the help of the state, are bound to suffer from a number of serious 'market failures'."[53]

It is the contention of this research that there are six primary biases, limits and self-imposed boundaries that currently guide the beliefs of health opinion formers.

The first is the concept of **monopoly**. It is commonly assumed that a health market is particularly vulnerable to monopoly and producer capture.

However, instead of seeing these traits as the weaknesses of statism and political culture it is an *a priori* belief amongst opinion formers that medical professions will be able to gain legislative favour and organise against the consumer to raise prices and to minimise accountability for medical wrongdoing. Crucially, the idea of precluding such legislative favour and of consumers becoming reliant on market-borne reputation (as opposed to regulation) is simply not articulated.

One of the ironies of the monopoly debate in health (and in other markets) is that those who often appear to be most concerned about it, invariably suggest that it should be the greatest monopolist of them all – the state – that is used to deal with the assumed problems that monopoly gives rise to.

The second issue is **consumer ignorance**. It is commonly held that because of his superior knowledge, the doctor will always face the consumer as the dominant party, and that this will be a problem made worse by medical advance.

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[53] Green, D., (1985) Working Class Patients and the Medical Establishment, Aldershot, Gower, p. 3.

Here there appears to be little understanding or empathy for the view that brands, reputation and third party assessments, essential features of a free society, can overcome many of the problems of consumer ignorance. There is little faith in the idea that the market would discover overtime means and mechanisms that would empower and embolden the consumer. Again, the idea that state monopoly or regulation would in anyway empower the consumer more than a genuine market is an interesting yet questionable notion.

The third area of popular concern is **neglect of the poor and chronically sick**. Here, it is believed that even if the market does not wholly neglect the poor and chronically sick, they would inevitably receive an altogether inferior service.

Instead of seeing the market as an instrument that offers built-in incentives to level social power and encourage greater prosperity for the benefit and inclusion of all, it is seen as a divisive mechanism that perpetuates exclusion and poverty. There is little assertion that it is the state that neglects the poor and the chronically sick because they hold less voice and power under its auspices.

Again, as Hayek, Mises and Rothbard have indicated there is little understanding that in a real market new and innovative enterprises and brands would emerge to deal with such vulnerable groups and in ways that are not currently thought of.

The fourth area is **externalities**. It is widely believed that there are negative externalities of third-party effects requiring government regulation, notably that the doctor and the patient may ignore the exposure of others to contagious disease. Here it is popularly assumed that a state will respond faster and more effectively to an external problem than a genuine free market.

The fifth area is a lack of provision of **public goods**. Under this argument it is held that some health care is a 'public good' and as such it must be supplied

by government. Perhaps the most popular reason for seeing health as a public good is the idea that only government can effectively manage and eliminate an outbreak of a contagious disease.

Instead of arguing that the market would itself create effective mechanisms and means to deal with such a situation, government is viewed *a priori* as the only agency capable of effective management. Importantly, when it comes to the public goods debate, there is little questioning of the capacity for politicians to cover-up, to deny, to obfuscate on, to misdirect, and to mismanage - not least because states invariably lack the sophisticated means by which vital evaluations and assessments can be encouraged.

The final argument popularly invoked to site market failure is the **perverse incentives of insurance.** Here, it is argued that demand for healthcare is more uncertain than for most other products and in practice this has meant that insurance has played a major role in health care funding. As such, it is said that there are special difficulties with health insurance. Once a person is covered by insurance he has a reduced incentive to avoid health care costs.

Similarly, once premiums have been paid the individual has an incentive to initiate the delivery of health care - that is, to 'get his money's worth'. Finally, where a third party does not control payment, the doctor or the patient may have an incentive not to contain costs.

In all of this, there has been scant regard for the perverse incentives of state healthcare. Just because the demand for healthcare might be more uncertain than for most other products it does not necessarily follow that government is better placed to deal with this than powerful consumers in real markets would be.

While it is popularly assumed that insurance is the private model of choice, it remains possible that in a real market other arrangements would become the norm. For example, it is often said that in a free market many uninsured motor accident victims would simply be left to die by the side of the road. But would

this really happen? Would a market not develop whereby some health providers offered free rescue and medical treatment providing the victim signed up to a health plan for a specified period. After all, this is precisely how many motor vehicle accident organisations such as the Automobile Association and the Royal Automobile Club work now.

Again, is it not true that once a person has been promised free and unlimited healthcare by a government this reduces the incentive to avoid health care costs?

Once taxes have been paid and the government has made this promise, do not individuals have an incentive to initiate the delivery of health care and to 'get what is theirs by right'?

Finally, why would it be assumed that in a real market the doctor or the patient would not have adequate incentives not to contain costs? Surely, that is what markets arrange in and of themselves? The suggestion that governments (as third party payers), can better ensure such an efficient outcome, is surely a highly questionable and contentious proposition?

Whilst one of the key teachings of social science is that we are all ultimately bound by the beliefs and epistemology of our age, it is nevertheless, as Anthony Giddens has so powerfully argued,[54] a primary function of those formally engaged in social enquiry to challenge and expose the boundaries, inconsistencies and contexts in which worldviews become accepted and are ultimately internalised.

In exploring the underlying beliefs and values of health opinion formers in the context of how they think about notions of market failure and market success, it was decided early on that such an inquiry would be suitable for both quantitative and qualitative research.

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[54] Anthony Giddens (1976) New Rules of Sociological Methodology, London, Hutchinson.

The quantitative research was gathered though a telephone questionnaire and interview with each respondent. Containing a series of questions that explored the respondent's values, ideas and notions surrounding such areas as monopoly, consumer ignorance, neglect of the poor and chronically sick, externalities, public goods, and perverse incentives, a subsequent analysis of the data gathered facilitates insights into the nature and degree of the boundaries and intellectual limits that opinion formers currently set.

Although social inquiry is never value free, quantitative research in the form of a questionnaire does facilitate a certain degree of dispassionate objectivity. Through the setting of methodologically appropriate questions, a number of statistical tools can be applied which in turn help to interpret and contextualise the insights gained.

To further aid analysis, the qualitative research of this study has also been facilitated by a series of open-ended questions towards the end of each telephone interview. While such work - as Ann Bowling points out – often tends to lack external validity:

> "The aim is to understand complex phenomena and to generate hypotheses, rather than to apply the findings to a wider population".[55]

Given the subject matter and the constraints of undertaking this research, it is inevitable that the data and information achieved would have to be interpreted to some extent.

However, given the powerful results achieved and outlined in Chapter VI, it is only fair to say that the explanations provided are not a matter of subjective, personal opinion, but instead, accurately reflect the values, beliefs and boundaries of the population concerned.

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[55] Ann Bowling (2000) Research Methods in Health: Investigating Health and Health Services, Open University Press, Maidenhead, p. 190.

The Sample

As suggested above, the sample for this study covers the influential worlds of journalism, academia, politics, civil service - and key interest groups.

For reasons of definitional complexity and because of the sensitivity of the research (not least for reasons of individual confidentiality), it was not possible to examine a 'perfect' sample. Nevertheless, the research compiled is from an accurate and representative sample of leading national newspaper, electronic media, party political, civil service, and health interest group commentators.

It is estimated that out of the leading national newspapers, the author questioned more than 90 per cent of currently serving and recent health correspondents. Ten leading national health journalists were interviewed (see Table 1).

Concerning the electronic media, ten leading health correspondents and journalists from the BBC, Independent Television News and Sky News were interviewed.

Similarly, ten leading health and social policy academics were interviewed. All of them work in some of Britain's most respected university departments, have written several books on healthcare and social policy, and/or regularly appear as commentators on health in the press and media.

In politics, a sample of 10 past and current health spokesmen were interviewed from the country's main political parties – Labour, Conservative and Liberal Democrat - including those ranked at ministerial, junior ministerial and backbench levels.

To further strengthen the parliamentary sample ten past and present members of the House of Commons Health Select Committee were interviewed.

To access party policy expertise, ten party political advisers and researchers on health policy and social policy were interviewed. Concerning the civil service, ten senior officials from the Department of Health and other key ministries – such as the Treasury - were interviewed.

Ten senior respondents were interviewed from a wide range of health interest groups. These included respondents from the General Medical Council, the British Medical Association, a selection of Royal Medical Colleges, leading health trades unions, private sector organisations, charities, and patients groups.

Ten leading public policy thinkers from a selection of think tanks were interviewed.

Finally, ten senior medical and health professionals were interviewed.

Sample Frame	**Number of Respondents**
1. Newspaper Health Journalists	**10**
2. Electronic Media Health Journalists	**10**
3. Health and Social Policy Academics	**10**
4. Party Political Health Spokesmen	**10**
5. Members of the House of Commons Health Select Committee	**10**
6. Party Political Advisers on Health and Social Policy	**10**
7. Senior Civil Servants	**10**
8. Health Interest Groups	**10**
9. Think Tanks	**10**
10. Senior Medical and Health Professionals	**10**

Table 1.

Combined, a list of one hundred leading health commentators were surveyed making this the largest ever analysis of notions of market failure and success amongst influential British opinion formers.

From the outset, respondents were told that the information gathered was for an academic thesis concerned with the analysis of notions of market failure and success in healthcare.

Given the political sensitivities surrounding this subject, the respondents were assured that their anonymity would be guaranteed at all times and that their identities would not be revealed.

The research was conducted between 15th November 2004 and 15th April 2005. Throughout the process, it was made clear that what were wanted was the respondent's own personal views.

As such, 'don't know' (DK) options were not included in the quantitative research because, as Schuman and Presser advised, in a survey like this, which is interested in people's underlying dispositions, it is better to encourage a definite 'one way or the other' response by not providing a "get out".[56]

Overall, as will be seen in the next chapter, there was an unusually low level of non-response. The data achieved was generated from one hundred percent of the initial sample frame.

Important Research

This research is of fundamental importance because it seeks to illuminate the boundaries, limits and presumptions upon which one of the most important debates of our civilisation is conducted.

For the discourse surrounding the economics and politics of healthcare is not simply relevant to Britain and the National Health Service. It has wider global implications that potentially impact on the lives of millions of humans around the world.

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[56] Schuman, H., and Presser, S., (1981) Questions and Answers in Attitude Surveys, New York, Academic Press.

It is perhaps a timeless truth that all humans require some degree of healthcare during the course of their lives. Medicine, healthcare and the fellow-feeling that should accompany them are a vital and necessary ingredient of all human life.

Today, in 2006, Britain remains the fourth largest economy in the world. It is one of the world's leading industrial nations. And its economic, military and cultural prowess carries huge international weight and influence. As a world connected in real-time increasingly speaks English as an international language, then what is done in health policy, in Britain, really does matter.

For whilst during the first six decades of the twentieth century British Fabian socialists sought to export their ideas on health, welfare and economics to foreign and commonwealth nations around the world,[57] Britain's policy exporters now seem to have become, the primary champions of a new corporatist project: namely, public private partnerships.

In the broader political, economic and cultural context, the way leading British health opinion formers think about healthcare, and the economic rubrics that of necessity underpin it, are of huge significance.

For as the twenty first century opens up before us and the world of healthcare leaves behind the model of full blown nationalisation, the question arises as to what will replace it? If its emergent demise suggests a transition or a vacuum, what will be underlying principles that guide market-inclined reform?

In the future, will opinion formers continue to perpetuate historic notions of market failure in healthcare or give new voice to notions of government failure? When it comes to markets in health, is there intellectual scope amongst opinion formers for notions of market success?

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[57] Donald F. Butsky, (2000) Democratic Socialism: A Global Survey, Praeger, Connecticut, Westport.

CHAPTER VI
IDEAS OF MARKET AND GOVERNMENT FAILURE AMONGST BRITISH HEALTH OPINION FORMERS

In exploring and questioning notions of market and government failure in healthcare, this chapter presents the results of research from one hundred leading opinion formers. In clarifying the conceptual boundaries surrounding commonly held notions of health economics, it seeks to expose some of the current healthcare debate's limitations and deficiencies.

Research Findings

As was made clear in Chapter V, the research element of the study centred on a telephone interview and questionnaire that was used between 15th November 2004 and 15th April 2005. Overall, 100 respondents were chosen in the sample frame, 10 from each of the following categories of opinion former: newspaper health journalists, electronic media health journalists, health and social policy academics, party political health spokesmen, members of the House of Commons health select committee, party political advisers on health and social policy, senior civil servants, health interest groups, think tank policy experts, senior medial and health professionals.

100 per cent of the respondents fully participated in the research. Together, they account for a high percentage of British health opinion formers and as such the data generated can be said to have a high degree of external validity.

The survey itself was divided into three sections. The first two sections sought quantitative data with the third concentrating on qualitative information. The first section (Section A) dealt with 'Opinions towards Market Failure in healthcare' and the second (Section B) concentrated on 'Opinions towards Government Failure in healthcare'. The third section (Section C) concerned general 'Parameters in the healthcare debate'.

In total, there were 21 questions with 7 in section A (1-7), 7 in section B (8-14) and 7 in section C (15-21).

Questions 1 to 7 invited respondents to agree or disagree with particular statements. For each question, respondents were given the following instruction: "On a scale of 1-10, with 1 being 'strongly disagree' and 10 being 'strongly agree' can you please tell me what you think of the following statement".

Q.A1. "If a real market in healthcare existed, Government would still have to intervene to stop problems of Monopoly."											
	1	2	3	4	5	6	7	8	9	10	Avg.
Newspaper health journalists	0	0	0	0	2	2	3	2	1	0	5.4
Electronic media health journalists	1	0	2	0	2	0	0	2	0	3	6.3
Health and social policy academics	4	0	1	1	0	1	0	2	0	1	4.3
Party political health spokesmen	1	2	1	0	1	0	2	1	2	0	5.3
Members of the H of C health select committee	0	0	0	1	1	2	0	2	2	2	7.5
Party political advisers on health and social policy	0	0	1	1	1	1	1	4	0	1	6.7
Senior civil servants	0	2	3	0	0	1	0	0	1	3	5.6
Health interest group representatives	0	0	1	0	0	1	3	1	0	4	7.8
Think tank policy experts	2	2	1	0	1	0	0	3	1	0	4.7
Senior medical and health professionals	1	0	1	1	3	0	2	2	0	0	5.3
Totals	9	6	11	4	11	8	11	19	7	14=100	
									Overall Average		5.9

In response to the statement "If a real market in healthcare existed, Government would still have to intervene to stop problems of monopoly" all respondent categories answered within the (slightly negative) 4.3 to (reasonably positive) 7.8 range. Overall, the opinion forming 100 averaged a score of 5.9.

Nevertheless, below this headline average there were some important differences. While health interest group representatives (7.8), party political advisers (6.7) and electronic media journalists (6.3) tended to agree with the view that government would have to stop problems of monopoly there was clearly more caution from the health and social policy academics (4.3) and the think tank policy experts (4.7). The latter appeared to be much more

questioning of the notion of monopoly and somewhat sceptical of the benefits of government interventionism.

Q.A2 "If a real market in healthcare existed, Government would still have to intervene to provide objective information to overcome problems of Consumer Ignorance".											
	1	2	3	4	5	6	7	8	9	10	Avg.
Newspaper health journalists	0	0	2	0	0	0	5	0	2	1	6.9
Electronic media health journalists	0	0	0	0	2	1	2	1	1	3	7.7
Health and social policy academics	4	0	0	0	0	1	0	2	0	3	5.6
Party political health spokesmen	0	1	1	0	0	2	3	2	1	0	6.3
Members of the H of C health select committee	0	0	1	1	0	0	3	2	3	0	7.1
Party political advisers on health and social policy	0	0	3	2	0	1	1	0	0	2	5.0
Senior civil servants	2	0	2	3	0	0	1	2	0	0	4.3
Health interest group representatives	0	1	0	0	2	1	0	2	0	4	7.4
Think tank policy experts	4	1	1	1	1	0	2	0	0	0	3.2
Senior medical and health professionals	1	0	1	3	0	1	1	3	0	0	5.3
Totals	11	3	11	10	5	7	18	14	7	14=100	
									Overall Average		5.8

In response to the statement "If a real market in healthcare existed, Government would still have to intervene to provide objective information to overcome problems of consumer ignorance" all respondent categories answered within the relatively wide (negative) 3.2 to (reasonably positive) 7.7 range. Overall, the opinion forming 100 averaged a score of 5.8.

Nevertheless, below this figure there were some important differences. While electronic media health journalists (7.7), health interest group representatives (7.4) and newspaper health journalists (6.9) tended to agree with the view that government would have to provide objective information to overcome problems of consumer ignorance there was clear scepticism from the think tank policy experts (3.2).

This latter group appeared to be not only more questioning of the notion of objective information per se but were sceptical of it when its codification and dissemination was attempted through government intervention.

Q.A3 "If a real market in healthcare existed, Government would still have to intervene to protect the Poor and Chronically Sick from Neglect."											
	1	2	3	4	5	6	7	8	9	10	Avg.
Newspaper health journalists	0	0	0	0	0	1	2	1	3	3	8.5
Electronic media health journalists	0	0	0	0	0	0	1	0	2	7	9.5
Health and social policy academics	2	1	0	0	2	0	1	0	1	3	6.0
Party political health spokesmen	1	0	0	0	0	1	1	3	2	2	7.6
Members of the H of C health select committee	0	0	0	0	0	0	2	1	1	6	9.1
Party political advisers on health and social policy	0	0	1	1	1	1	2	1	0	3	7.0
Senior civil servants	2	0	0	2	1	0	2	1	0	2	5.7
Health interest group representatives	0	0	0	1	0	0	2	1	1	5	8.5
Think tank policy experts	2	1	1	0	1	1	0	1	1	2	5.5
Senior medical and health professionals	1	0	1	1	0	2	1	3	1	0	6.0
Totals	8	2	3	5	5	6	14	12	12	33=100	
									Overall Average		7.3

In response to the statement "If a real market in healthcare existed, Government would still have to intervene to protect the poor and chronically sick from neglect" all respondent categories answered within the relatively wide (neutral) 5.5 to (very positive) 9.5 range. Overall, the opinion forming 100 averaged a reasonably positive score of 7.3.

Nevertheless, below this figure there were some important differences. While electronic media health journalists (9.5), health interest group representatives (8.5) and newspaper health journalists (8.5) tended to agree with the view that government would have to intervene to protect the poor and chronically sick from neglect there was a seemingly neutral scepticism from the think tank policy experts (5.5), senior civil servants (5.7), the health and social policy academics (6.0) and the senior medical and health professionals (6.0).

While the think tank policy experts, civil servants and the health and social policy academics were at best neutral towards the idea of government interventionism benefiting the poor and chronically sick a similarly neutral stance from the senior medical and health professionals might have come from the perspective that they - not central government - are best placed to help the poor and chronically sick.

Q.A4. "If a real market in healthcare existed, Government would still have to intervene to help protect people from such external factors as contagious disease."											
	1	2	3	4	5	6	7	8	9	10	Avg.
Newspaper health journalists	0	0	0	0	1	0	1	1	2	5	8.8
Electronic media health journalists	0	1	0	0	0	0	0	1	2	6	8.8
Health and social policy academics	0	2	1	0	1	0	0	2	1	3	6.7
Party political health spokesmen	0	1	0	0	0	0	2	1	1	5	8.3
Members of the H of C health select committee	0	0	0	0	0	0	0	2	2	6	9.4
Party political advisers on health and social policy	0	0	3	0	0	1	0	1	1	4	7.2
Senior civil servants	0	0	2	1	0	0	3	0	1	3	7.0
Health interest group representatives	0	0	0	0	0	0	3	1	1	5	8.8
Think tank policy experts	0	1	0	0	4	1	1	2	0	1	6.1
Senior medical and health professionals	1	0	1	2	2	1	1	1	0	1	5.3
Totals	1	5	7	3	8	3	11	12	11	39=100	
									Overall Average		7.6

In response to the statement "If a real market in healthcare existed, Government would still have to intervene to protect people from such external factors as contagious disease" all respondent categories answered within the (neutral) 5.3 to (very positive) 9.4 range. Overall, the opinion forming 100 averaged a positive score of 7.6.

Nevertheless, below this figure there were some important differences. While members of the House of Commons Health Select Committee (9.4), electronic media health journalists (8.8) newspaper health journalists (8.8) and health interest group representatives stood out as tending to agree with the view that government would have to protect people from such external factors as contagious disease there was a more neutral stance from the senior medical and health professionals (5.3) and the think tank policy experts (6.1).

While members of think tanks might be in the business of challenging seemingly plausible assumptions, with senior medical and health professionals it is possible that their neutrality stems from the fact that they see themselves as being much more relevant to the protection of people from contagious disease than any government agency or department. In short, they see themselves as independent agents and advocates on the frontline of healthcare delivery.

Q.A5. "If a real market in healthcare existed, this would not stop some of it being run by government because healthcare is a natural public good."											
	1	2	3	4	5	6	7	8	9	10	Avg.
Newspaper health journalists	0	1	1	1	1	0	3	1	0	2	6.3
Electronic media health journalists	1	0	0	0	2	1	0	1	2	3	7.3
Health and social policy academics	5	1	1	0	1	0	1	1	0	0	3.0
Party political health spokesmen	2	3	0	1	1	1	1	1	0	0	3.8
Members of the H of C health select committee	0	1	0	1	0	1	2	0	4	1	7.2
Party political advisers on health and social policy	1	1	2	1	2	1	1	0	0	1	4.6
Senior civil servants	4	0	0	1	0	1	1	0	2	1	4.9
Health interest group representatives	0	0	2	1	0	1	3	2	0	1	6.3
Think tank policy experts	4	1	4	0	0	1	0	0	0	0	2.4
Senior medical and health professionals	2	0	0	0	3	0	2	3	0	0	5.5
Totals	19	8	10	6	10	7	14	9	8	9=100	
									Overall Average		5.1

In response to the statement "If a real market in healthcare existed, this would not stop some of it being run by government because healthcare is a natural public good" all respondent categories answered within the relatively wide (negative) 2.4 to (positive) 7.3 range. Overall, the opinion forming 100 averaged a controversial score of 5.1.

Nevertheless, below this figure there were some important differences. While electronic media health journalists (7.3) and newspaper health journalists (6.3) tended to agree with the statement that healthcare is a natural public good there was clear disagreement from think tank policy experts (2.4) and health and social policy academics (3.0).

Such strong rejections from these two latter respondent groups suggest that they either saw the question as being contentious or they view healthcare as being a natural private good.

Q.A6. "Because people's healthcare is unpredictable some of its costs will always have to be covered by government – private arrangements such as insurance cannot do it all."											
	1	2	3	4	5	6	7	8	9	10	Avg.
Newspaper health journalists	0	1	0	1	0	0	4	1	1	2	7.1
Electronic media health journalists	0	0	0	1	1	0	1	2	2	3	8.0
Health and social policy academics	3	0	0	0	1	0	2	1	1	2	5.9
Party political health spokesmen	1	0	0	0	1	0	1	3	2	2	7.5
Members of the H of C health select committee	0	0	0	1	0	0	0	3	1	5	8.7
Party political advisers on health and social policy	0	4	1	0	1	1	0	2	0	1	4.8
Senior civil servants	3	1	3	0	1	0	1	0	1	0	3.5
Health interest group representatives	0	0	0	1	1	1	2	1	1	3	7.6
Think tank policy experts	3	1	1	0	2	1	0	1	0	1	4.2
Senior medical and health professionals	1	0	3	0	0	0	2	4	0	0	5.6
Totals	11	7	8	4	8	3	13	18	9	19=100	
									Overall Average		6.2

In response to the statement "because people's healthcare is unpredictable some of its costs will always have to be covered by government – private arrangements such as insurance cannot do it all", all respondent categories answered within the relatively wide (negative) 3.5 to (positive) 8.7 range. Overall, the opinion forming 100 averaged a slightly positive score of 6.2.

Nevertheless, below this figure there were some important differences. While members of the House of Commons Health Select Committee (8.7), electronic media health journalists (8.0) and newspaper health journalists (7.1) tended to agree with the statement that 'because people's healthcare is unpredictable private arrangements such as insurance cannot do it all', senior civil servants (3.5) the think tank policy experts (4.2) and party political advisers on health and social policy (4.8) all disagreed.

Expressing neutrality were the senior medical and health professionals (5.6) and the health and social policy academics (5.9).

Q.A7. "If people are covered by private healthcare, there is a greater incentive for them to use it and get their money's worth."											
	1	2	3	4	5	6	7	8	9	10	Avg.
Newspaper health journalists	0	0	1	0	3	0	2	3	1	0	6.5
Electronic media health journalists	0	1	0	1	0	0	1	3	2	2	7.5
Health and social policy academics	1	0	1	1	0	1	3	1	0	2	6.3
Party political health spokesmen	2	1	0	0	3	2	2	0	0	0	4.5
Members of the H of C health select committee	0	0	0	1	0	0	4	2	2	1	7.6
Party political advisers on health and social policy	0	0	1	2	0	3	1	3	0	0	6.0
Senior civil servants	4	0	2	0	0	0	1	1	2	0	4.3
Health interest group representatives	0	1	1	2	4	0	1	0	0	1	5.0
Think tank policy experts	1	0	1	0	1	1	2	2	1	1	6.4
Senior medical and health professionals	0	0	0	3	1	0	1	2	3	0	6.7
Totals	8	3	7	10	12	7	18	17	11	7=100	
									Overall Average		6.0

In response to the statement "if people are covered by private healthcare, there is a greater incentive for them to use it and get their money's worth" all respondent categories answered within the (slightly negative) 4.3 to (reasonably positive) 7.6 range. Overall, the opinion forming 100 averaged a slightly positive score of 6.0.

While senior civil servants (4.3), party political spokesmen (4.5) and health interest group representatives (5.0) erred on the side of disagreement, members of the House of Commons Health Select Committee (7.6), electronic media journalists (7.5), senior medical and health professionals (6.7) newspaper health journalists (6.5) and think tank policy experts (6.4) tended to agree with the view that if people were covered by private healthcare they would have a greater incentive to use it.

The questions in section B - numbered 8 to 14 - again invited respondents to agree or disagree with particular statements. As with section A (above), but this time dealing with 'Opinions towards Government Failure in healthcare', each respondent was given the following instruction: On a scale of 1-10, with 1 being 'strongly disagree' and 10 being 'strongly agree' can you please tell me what you think of the following statement".

Q.B8. "If a system of real state healthcare existed, a market providing people with choices would still have to be allowed to stop problems of Monopoly."											
	1	2	3	4	5	6	7	8	9	10	Avg.
Newspaper health journalists	0	0	0	1	0	1	1	3	2	2	7.9
Electronic media health journalists	1	2	1	0	1	1	1	1	1	1	5.3
Health and social policy academics	0	0	1	0	1	1	1	0	1	5	8.0
Party political health spokesmen	2	0	1	0	1	0	1	3	0	2	6.1
Members of the H of C health select committee	1	0	0	1	0	3	1	2	2	0	6.4
Party political advisers on health and social policy	1	0	0	0	1	0	1	2	2	3	7.7
Senior civil servants	0	0	0	1	0	1	2	1	1	4	8.1
Health interest group representatives	0	1	2	0	1	2	0	1	1	2	6.2
Think tank policy experts	1	0	0	0	0	0	1	2	2	4	8.2
Senior medical and health professionals	0	0	2	2	0	4	0	0	1	1	5.7
Totals	6	3	7	5	5	13	9	15	13	24=100	
									Overall Average		6.9

In response to the statement "if a system of real state healthcare existed, a market providing people with choices would still have to be allowed to stop problems of monopoly" all respondent categories answered within the (neutral) 5.3 to (positive) 8.2 range. Overall, the opinion forming 100 averaged a reasonably positive score of 6.9.

Nevertheless, below this headline average there were some important differences. While think tank policy experts (8.2), senior civil servants (8.1) health and social policy academics (8.0), newspaper health journalists (7.9) and party political advisers on health and social policy (7.7) tended to agree with the view that if a system of real state healthcare existed, 'a market providing people with choices would still have to be allowed to stop problems of monopoly', health interest group representatives (6.2), party political health spokesmen (6.1), senior medical and health professionals (5.7) and electronic media health journalists (5.3) were all respondent categories that were much more middling in their answers.

Significantly, no respondent category overtly disagreed with the statement and therefore the idea that under real state healthcare a market providing people with choices would still have to exist if problems of monopoly were to be ameliorated.

Q.B9. "If a system of real state healthcare existed, people would have to be allowed to access a wide range of competing health information so that individuals could overcome the problems of Consumer Ignorance."											
	1	2	3	4	5	6	7	8	9	10	Avg.
Newspaper health journalists	0	0	0	2	1	0	0	0	1	6	8.2
Electronic media health journalists	0	0	0	0	2	0	1	1	3	3	8.2
Health and social policy academics	0	0	0	0	1	0	2	1	1	5	8.6
Party political health spokesmen	0	0	1	0	1	0	1	2	4	1	7.7
Members of the H of C health select committee	0	0	0	0	0	1	3	4	1	1	7.8
Party political advisers on health and social policy	0	0	0	0	0	1	3	1	2	3	8.3
Senior civil servants	0	0	0	0	0	0	1	3	1	5	9.0
Health interest group representatives	0	0	1	0	0	1	2	2	2	2	7.7
Think tank policy experts	0	0	0	0	1	0	2	1	3	3	8.4
Senior medical and health professionals	0	0	0	0	0	2	2	3	2	1	7.8
Totals	0	0	2	2	6	5	17	18	20	30=100	
								Overall Average			8.1

In response to the statement "if a system of real state healthcare existed, people would have to be allowed to access a wide range of competing health information so that individuals could overcome the problems of consumer ignorance" all respondent categories answered within a remarkably narrow, consensual and positive 7.7 to 9.0 range. Overall, the opinion forming 100 averaged a positive score of 8.1.

With all respondent categories generally agreeing with the idea that under state healthcare people would still require competing channels of health information to overcome the problems of consumer ignorance it was clear that the respondents were sensitive to the limits and unintended consequences of state power.

As if inherently accepting of the subjectivity of knowledge and the medical discovery process all categories seemingly accepted that a legal or black market in information would exist and help overcome the problems of consumer ignorance.

Significantly, no respondent category believed that a real state healthcare system could on its own overcome the problems of consumer ignorance.

Q.B10. "If a system of real state healthcare existed, there would still be a need for many private healthcare charities and groups to protect the Poor and Chronically Sick from Neglect."											
	1	2	3	4	5	6	7	8	9	10	Avg.
Newspaper health journalists	1	0	0	1	2	1	1	2	1	1	6.3
Electronic media health journalists	1	1	0	1	1	0	1	2	1	2	6.4
Health and social policy academics	0	1	1	0	0	1	2	1	0	4	7.3
Party political health spokesmen	0	1	2	0	0	0	2	2	2	1	6.6
Members of the H of C health select committee	0	1	0	0	0	0	0	2	4	3	8.4
Party political advisers on health and social policy	0	0	3	1	0	0	4	1	0	1	5.9
Senior civil servants	1	0	4	0	0	1	0	1	0	3	5.7
Health interest group representatives	0	0	1	1	0	1	1	2	1	3	7.5
Think tank policy experts	1	0	0	0	1	1	0	3	0	4	7.6
Senior medical and health professionals	0	3	2	0	0	0	1	2	1	1	5.4
Totals	4	7	13	4	4	5	12	18	10	23=100	
									Overall Average		6.7

In response to the statement "if a system of real state healthcare existed, there would still be a need for many private healthcare charities and groups to protect the poor and chronically sick from neglect" all respondent categories answered within a relatively narrow (neutral) 5.4 to (very positive) 8.4 range. Overall, the opinion forming 100 averaged a slightly positive score of 6.7.

While members of the House of Commons Health Select Committee (8.4), think tank policy experts (7.6), health interest group representatives (7.5) and health and social policy academics (7.3) all agreed with the inevitability of private healthcare charities and groups playing a vital role in protecting the poor and chronically sick from neglect – even under a system of real state healthcare - senior medical and health professionals (5.4), senior civil servants (5.7) and party political advisers on health and social policy (5.9) where less sure. For the latter three respondent categories such a view is more controversial.

Having said that, no respondent category overtly disagreed with the idea that under any state system private healthcare charities and groups will always have an important role to play for the poor and chronically sick.

Q.B11. "If a system of real state healthcare existed, private healthcare would still have to intervene to help protect people from such external factors as contagious disease."

	1	2	3	4	5	6	7	8	9	10	Avg.
Newspaper health journalists	3	2	1	0	1	1	1	1	0	0	3.6
Electronic media health journalists	2	4	3	1	0	0	0	0	0	0	2.3
Health and social policy academics	2	2	0	1	2	0	2	0	0	1	4.4
Party political health spokesmen	3	1	0	1	2	1	1	0	1	0	4.1
Members of the H of C health select committee	1	1	1	1	1	2	0	2	0	1	5.3
Party political advisers on health and social policy	2	1	5	1	0	1	0	0	0	0	2.9
Senior civil servants	4	0	3	0	1	0	1	0	0	1	3.5
Health interest group representatives	1	2	0	1	1	1	1	3	0	0	5.1
Think tank policy experts	1	1	0	0	2	1	0	2	1	2	6.5
Senior medical and health professionals	0	4	2	1	1	0	0	1	0	1	4.1
Totals	19	18	15	7	11	7	6	9	2	6=100	
									Overall Average		4.1

In response to the statement "if a system of real state healthcare existed, private healthcare would still have to intervene to help protect people from such external factors as contagious disease", all respondent categories answered within the relatively broad (very negative) 2.3 to (slightly positive) 6.5 range. Nevertheless, overall, the opinion forming 100 averaged a negative score of 4.1.

While think tank policy experts (6.5) just erred on the side of the positive, all the other respondent categories tended towards the negative. Electronic media health journalists (2.3), party political advisers on health and social policy (2.9) and newspaper health journalists (3.6) were all overt in their disagreement with the idea that private healthcare had much, if anything, to offer in terms of protection when it came to such external factors as contagious disease.

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Significantly, no respondent category overtly supported the idea that under a system of real state healthcare, private healthcare would have much to offer against the societal threat of contagious disease.

Q.B12. "If a system of real state healthcare existed, this would not stop some of it being run by a private market because healthcare is a natural private good."											
	1	2	3	4	5	6	7	8	9	10	Avg.
Newspaper health journalists	0	1	1	1	1	0	2	2	1	1	6.3
Electronic media health journalists	0	2	1	2	0	2	1	2	0	0	5.0
Health and social policy academics	1	0	0	1	1	1	2	1	0	3	6.8
Party political health spokesmen	0	1	1	0	1	1	2	1	3	0	6.5
Members of the H of C health select committee	1	1	1	0	2	4	0	0	1	0	5.8
Party political advisers on health and social policy	1	0	1	0	3	0	1	3	1	0	5.9
Senior civil servants	0	0	1	0	1	0	0	4	1	3	7.9
Health interest group representatives	0	0	1	1	1	1	0	4	0	2	7.0
Think tank policy experts	0	1	0	0	2	1	1	1	1	3	7.2
Senior medical and health professionals	1	2	0	0	2	1	0	3	0	1	5.5
Totals	4	8	7	5	14	11	9	21	8	13=100	
									Overall Average		6.3

In response to the statement "if a system of real state healthcare existed, this would not stop some of it being run by a private market because healthcare is a natural private good", all respondent categories answered within the relatively narrow (slightly negative) 5.0 to (positive) 7.9 range. Overall, the opinion forming 100 averaged a slightly positive score of 6.3.

While senior civil servants (7.9), think tank policy experts (7.2), health interest group representatives (7.0) and health and social policy academics (6.8) erred on the side of the positive, all the other respondent categories found the statement more controversial and therefore fell somewhere in the middle. Electronic media health journalists (5.0), senior medical and health professionals (5.5) and party political advisers on health and social policy (5.9) all provided middling scores.

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Significantly, no respondent category overtly disagreed with the view that under a system of real state healthcare some of it would still be run by a private market because healthcare is a natural private good.

Q.B13. "Because people's healthcare is unpredictable some of its costs will always have to be covered by private healthcare – government arrangements such as taxation cannot do it all."

	1	2	3	4	5	6	7	8	9	10	Avg.
Newspaper health journalists	0	1	0	0	1	4	0	1	1	2	6.8
Electronic media health journalists	2	1	2	1	2	0	0	1	1	0	4.1
Health and social policy academics	0	0	0	1	0	1	2	2	0	4	8.0
Party political health spokesmen	1	0	0	0	0	1	2	2	3	1	7.4
Members of the H of C health select committee	0	0	3	1	0	0	2	1	1	2	6.4
Party political advisers on health and social policy	1	0	0	1	1	0	3	1	1	2	6.8
Senior civil servants	1	1	0	1	1	0	2	1	0	3	6.4
Health interest group representatives	0	1	1	0	0	3	2	2	0	1	6.3
Think tank policy experts	0	1	0	0	2	0	0	2	0	5	7.8
Senior medical and health professionals	0	2	1	1	0	0	2	2	1	1	6.0
Totals	5	7	7	6	7	9	15	15	8	21=100	
									Overall Average		6.5

In response to the statement "because people's healthcare is unpredictable some of its costs will always have to be covered by private healthcare – government arrangements such as taxation cannot do it all", all respondent categories answered within the (slightly negative) 4.1 to (positive) 8.0 range. Overall, the opinion forming 100 averaged a slightly positive score of 6.5.

While health and social policy academics (8.0), think tank policy experts (7.8), party political advisers on health and social policy (6.8) and newspaper health journalists (6.8) were all positive, electronic media health journalists were negative (4.1). Senior civil servants (6.4), health interest group representatives (6.3) and senior medical and health professionals (6.0) provided more middling scores.

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Significantly, no respondent category profoundly disagreed with the view that 'because people's healthcare is unpredictable some of its costs will always have to be covered by private healthcare – government arrangements such as taxation cannot do it all'.

Q.B14. "If people are covered by state healthcare, there is a greater incentive for them to use it and get their money's worth."											
	1	2	3	4	5	6	7	8	9	10	Avg.
Newspaper health journalists	0	0	1	0	3	0	2	2	2	0	6.6
Electronic media health journalists	1	2	0	0	2	0	2	1	1	1	5.6
Health and social policy academics	0	0	1	1	1	0	2	0	0	5	7.6
Party political health spokesmen	0	1	2	0	1	1	2	2	1	0	5.8
Members of the H of C health select committee	0	1	0	0	1	0	1	2	2	3	7.8
Party political advisers on health and social policy	0	1	0	0	2	1	3	1	1	1	6.6
Senior civil servants	0	0	1	1	3	0	1	1	1	2	6.6
Health interest group representatives	0	1	1	2	2	1	1	1	0	1	5.4
Think tank policy experts	0	0	0	0	1	1	2	2	2	2	7.9
Senior medical and health professionals	0	0	2	0	1	2	0	1	2	2	6.9
Totals	1	6	8	4	17	6	16	13	12	17=100	
									Overall Average		6.6

In response to the statement "if people are covered by state healthcare, there is a greater incentive for them to use it and get their money's worth" all respondent categories answered within a (neutral) 5.4 to (positive) 7.9 range. Overall, the opinion forming 100 averaged a slightly positive score of 6.6.

While think tank policy experts (7.9), health and social policy academics (7.6) and senior medical and health professionals (6.9) were all positive, health interest group representatives (5.4) and electronic media health journalists (5.6) provided middling scores.

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Significantly, no respondent category profoundly disagreed with the view that 'if people are covered by state healthcare, there is a greater incentive for them to use it and get their money's worth'.

The questions in section C - numbered 15 to 21 – were more qualitative in their orientation. Seeking more open-ended and personal responses they sought to further clarify the conceptual boundaries surrounding commonly held notions of health economics and therefore to expose some of the current healthcare debate's limitations and deficiencies.

Question C15: In Healthcare, what would be the consequences of a genuine, private, market system?"

Question C15 demanded an open response to the following statement: "In Healthcare, what would be the consequences of a genuine, private, market system?"

In reply, most of the newspaper health journalists expressed concern with the "inequity" such a system would bring and they tended to focus on the consequences of a more open market in health information. While many saw limitations in such a system - "there would be an under class", "inequitable, expensive, big holes in the cover", "marginalise some, benefit lots, potentially inequitable", "could lead to a degree of exclusion for lower income people" – others stressed the perceived benefits: "better standards, increased competition and...increased access to information", "the well informed would do better", "eventual improvement to poor and chronically sick although possibly not in the transition period". Here, the overwhelming majority tended to associate a genuine private market with "greater cost" and more "expense". More and better information would disproportionately empower the better off.

Likewise, electronic media health journalists also tended to believe that such a system "would leave society's more vulnerable with an inferior service", "more would be spent on a system that covered fewer people...those who could afford more would get better healthcare". A genuine private market system "would neglect the needy and chronic illness", the "very poor would be very poorly served". As if a free market encourages a zero sum game with a fixed quality of wealth one respondent concluded "Doctors and nurses would go to better hospitals leading to a long term disaster". Another stated "Lack of access for less well off - better funded system in the short term".

Health and social policy academics were much more positive in their responses: "better access to services and more innovation", "everyone in society would be better off...poor would get better treatment and care", "lower

cost, diversity of approaches, fast medical progress". While one respondent concluded, "there would be more expenditure overall but there would also be better health for the same expenditure. Better quality, lower costs...more health for the buck, better outcomes", another asserted: "new medical techniques and funding mechanisms would be discovered that we currently cannot imagine".

The responses from the party political health spokesmen were very mixed. While some saw "greater diversity of provision", "more incentive to improve", "less waiting", "greater choice" and ""people would have a [greater] interest in their own health", others asserted: "could lead to problems for some", "chronically sick [would be] uninsurable and dependent on charity", "look at the USA to see private market horror". While generally believing the market would be more "efficient", most remained worried about the poor and long term ill.

Overseen by majority of Labour members of parliament, most respondents from the House of Commons Health Select Committee tended to the negative. For them, a genuine private market would encourage the "poor to go back to a dark Victorian age". It would be "too expensive" with "little investment for the poor". That said there were also members who asserted "would need partnership, private health is strong on quality", "much better for everyone, state healthcare has not been good for the poor", and "much better patient focused service". While one person interpreted the question in the immediate terms of the NHS, "disaster for the health service", another stated "quicker".

The party political advisers on health and social policy were strikingly positive. They saw a genuine private market health system as being "cheaper, faster, better, more democratic", "lead to higher standards, "[greater] innovation and higher efficiency...over time lower costs", "more efficient, health outcomes improved, poor in all probability would receive better care than in state system", "quicker", "consumer power, better access, higher standards of responsiveness", "allow growth" and even "address more need, allow a thousand blooms to flourish". Indeed, in this group there were only three

negative respondents: "rising drug prices", "lack of universal coverage" and "put more pressure on health infrastructure".

For senior civil servants the picture was mixed. Some were clearly worried by the notion of a genuine market and what it might mean: "poorer and more deprived communities would suffer unless there was safeguards", "government would have to regulate to ensure fairness" and "[would require] government as purchaser especially with chronic disease" were all common responses. Others welcomed a market approach asserting: "increased accessibility, drive up quality", "appropriate use of resources, better informed consumer decisions", "better outcomes for consumers" and "better innovation, better healthcare at lower cost".

Health interest group representatives gave, as one might expect, a wide ranging and varied set of responses. While some were concerned with the issues of inequality and poverty, others saw it as providing a framework for more choice, better quality and greater efficiency. On the negative side: "inequality and increased quality for the rich", "more expensive, unnecessary duplication", "those with low incomes would not be able to pay", "disasterous...it is not the same as running Tescos. In healthcare there are not consumers. People are not capable of being consumers", "costs would be high". On the positive side: "more personal ownership of responsibility for health", "people would need to know more about shopping around for insurance policies etc", "plurality of provision [would lead to] more efficient allocation of resources, greater choice [and] possibly better quality".

Alongside the party political advisers on health and social policy (above) the think tank policy experts tended to see a genuine private market in positive terms. For them, such a system would deliver: "much easier access...[and] more new practice [such as] mobile operating theatres". It would also offer "higher standards for all, universal access not achieved at present", "vast, vast, vast improvement, service up, prices down, [as with] cosmetic surgery there would be a true market with lots of competition", "vast improvement, like food and electronics", "greater efficiency and choice, lower costs for

individuals, greater innovation through competition", "more equitable access". Here, negative comments were hard to come by although a couple of respondents did assert: "But you need a mix", "many people uncovered could not afford insurance, [here, the] state would have to intervene".

The final group, the senior medical and health professionals, tended to be negative about a genuine market system. Their comments included "generally, the poor would be disadvantaged", "tiered approach [would] produce vulnerable at risk groups", "weakest to the wall", "disaster, you need combination of private and NHS", "would exclude some people", "a two tier health service providing healthcare on demand to those who could afford it", "some people unable to access [healthcare] like in the USA". The few positive comments included: "competition could only be good", "people would take better care of themselves...more innovation", and "more choice".

Question C16: "In Healthcare, what would be the consequences of a genuine, full blown, state system?"

Mirroring C15 (above), C16 asked for open responses to the statement: "In healthcare, what would be the consequences of a genuine, full blown, state system?"

As with C15, many of the newspaper health journalists expressed an interest in 'information' – "reduced access to information" - as well as other domains. Overall, the journalists were damning of a genuine, full blown, state system: "very limited choice, lack of innovation, patients not getting the best, corruption", "lack of innovation, slow to introduce new treatments, insensitive to patient choice and demand", "waiting lists, lack of choice, rationing", "reduced research and development, delays, inefficient distribution". On the positive side, some of the responses were self consciously utopian: "couldn't exist, would always be mixed", "ironically, much more likelihood of two tier system postcode lottery", "in an ideal world good well costed health provision for all, but less choice and freedom."

The electronic media health journalists tended to believe that such a system "would be very expensive and inefficient, taxation would go up and up", "higher taxation and rationing", "bureaucratic and slow moving". While one respondent commented "the NHS is pretty close to this" another retorted "long term decline in service and delivery as no private sector benchmark. With no pressure on doctors and hospitals to treat people as customers [we] will be stuck in the 1970s". Here only one respondent was positive: "if affordable, ideal. If a good state system evolved needs would be met".

The health and social policy academics were damning in their responses: "shortages, crisis over rationing, people who would go abroad to exercise choice", "inconsistency between expectations and availability", "everyone worse off. Poorest and most inarticulate would die [as in] Soviet Russia and North Korea. No innovation", "poor quality, less choice". Significantly, some respondents in this group questioned the medical monopoly that currently underpins all systems of healthcare and even the impact that a full blown state healthcare would have on healthcare workers: "unless the problem of medical professional monopoly is dealt with it would be as inefficient as it is today", "less opportunity for healthcare workers".

While responses from the party political health spokesmen were mixed many highlighted their concerns with rationing by mentioning queues: "Monopoly purchaser, restrictions on supply, queuing", "reasonable for sick and poor, but queues", "queues and more rationing", "quality less good than it could be, rationing by queuing", "if there was no rationing, the sky would be the limit in terms of cost. However, this would lead to lots of wasted resources. There would have to be rationing otherwise the treasury would be crippled. This rationing would be through queues, waiting lists or discrimination". 80 per cent of respondents in this group complained about rationing, high costs, and the perceived inevitability of queuing.

Although with C15 (above) many respondents from the House of Commons Health Select Committee appeared to be opposed to a genuine private market

in health, when asked to comment on a full blown state system they were equally scathing: "death, bad service", "would require higher taxes", "could not afford it...unrealistic utopia", "more problems, thank god we have always had a private health sector that can now be exploited", "impossible, non starter, would bankrupt country", "bureaucracy, slow", "more equity but queues and lack of money", "better for poor, slower...for society". In this group only one person was overtly supportive: "decent healthcare for everyone irrespective of their background, birth and status in life, good healthcare for all is the ideal, it is possible".

The party political advisers on health and social policy were strikingly negative. They saw a genuine full blown state healthcare system in the following terms: "higher costs, more middle class capture, less accountability", "corruption, inefficiency, grotesque inequalities of outcome and a black market in private care", "shortages of doctors and nurses", "mediocrity of service", "disaster, the more statist the more a disaster, mass production, lowest common denominator", "lack of drug innovation", "poor research and development". The positive comments were: "you need state and private in competition to make a good system" and "greater universal access".

For senior civil servants the picture would be universally worse: "low dynamic efficiency in the medium to long term", "worse than now, efficiency and equality down, longer waiting", "inappropriate resource allocation", "risk of no innovation", "inefficient", "poor quality, monopoly, lack of incentive to improve", "Sovietisation, statistics bound system, lies told as route to promotion", "not customer facing", "provider inefficiency", "worse for patients than now".

The health interest groups gave a varied set of responses. On the negative side: "arrogant monopoly provider, patients would have little incentive to have knowledge or information about health and healthcare", "there would always be...constraints and longer waits", "no choice, public sector is fraught with supply and demand problems", "a full blown system would be a heavy burden on the tax payer", "monopolistic, unresponsive services", "lack of access to information, quality levels at a minimum, rising costs", "failure, failing

standards, system...scuppered by demand, low capital investment". On the positive side: "There would be universal coverage, higher standards throughout the service, a higher amount of GDP would go to healthcare. No waiting lists", and "everyone would achieve equitable treatment in quality and speed if paid for by taxation".

The think tank policy experts tended to see a genuine full blown state healthcare system in negative terms. For them, such a system would deliver: "rationing by queuing, failing standards, monopoly", "lowering of standards", "monopoly, no incentives to improve", "complete mess", "catastrophic, they would only get contagious diseases right but then only vaguely", "unaccountable, inability to provide basic uniform level of service, impersonal", "poor cost control, inequitable access, no universal coverage", "much worse, rhetorical equality, inefficient allocation of resources, over consumption, very poor spending on good practice", "failing provision, lack of incentive, lack of efficiency, low innovation and choice".

With the senior medical and health professionals the responses were mixed. Welcoming the statement, respondents said: "improvement on present", "should give equal access and quality based on demand, if adequately resourced", "if it worked...people would get appropriate care". On the negative side: "doctors become lazy and provide inadequate care, politicians become gods", "not enough money could be provided by taxation to have a full blown state system, lack of choice", "disaster, need a mixture", "very high costs, could take up to 100 per cent of taxation, government could not keep up with service and technological developments", "higher taxes, expensive, very costly".

Q.C17. "In healthcare, which is more prone to the problems of monopoly?"		
	The State	The Market
Newspaper health journalists	10	00
Electronic media health journalists	06	04
Health and social policy academics	09	01
Party political health spokesmen	10	00
Members of the H of C health select committee	07	03
Party political advisers on health and social policy	08	02
Senior civil servants	10	00
Health interest group representatives	08	02
Think tank policy experts	10	00
Senior medical and health professionals	04	06
Totals	82	18

Question C17 stated: "in healthcare, which is more prone to problem of monopoly – the state or the market?" In response, an overwhelming 82 per cent said the state with only 18 per cent choosing the market.

Moreover, all respondent categories chose the state except for one single group. From the respondent category senior medical and health professionals 60 per cent voted for the market while 40 per cent voted for the state.

Significantly, 100 per cent of think tank policy experts, newspaper health journalists, party political health spokesmen and civil servants chose the state as did 90 per cent of health and social policy academics, 80 per cent of health interest group representatives and 80 per cent of party political advisers on health and social policy.

Q.C18. "In healthcare, which two of the following four groups has most to gain from statutory restrictions on the advertising of medicines?"				
	Medical Professionals	Private health bosses	Treasury Ministers	Consumers
Newspaper health journalists	05	02	10	03
Electronic media health journalists	08	01	06	05
Health and social policy academics	08	04	07	01
Party political health spokesmen	05	03	09	03
MPs on H of C health select committee	03	04	09	04
Party political advisers on health/soc policy	06	04	10	00
Senior civil servants	07	02	07	04
Health interest group representatives	06	04	05	05
Think tank policy experts	09	00	10	01
Senior medical and health professionals	04	05	08	03
Totals	61	29	81	29

Question C18 stated: "in healthcare, which two of the following four groups has most to gain from statutory restrictions on the advertising of medicines: medical professionals, private health bosses, treasury ministers, consumers?"

In response, an overwhelming majority 81 per cent chose treasury ministers and a reasonable majority - 61 per cent - chose medical professionals. The other two groups - private health bosses and consumers – tied with both receiving 29 per cent.

These headline numbers are important because they suggest that the respondents overwhelmingly see the statutory restrictions on medicines as primarily benefiting cost-containing politicians – in this case treasury ministers. Likewise a majority (61 per cent) see such restrictions as enhancing the professional power of the medical interest.

Significantly, while 90 per cent of think tank policy experts view medical professionals as being key beneficiaries of statutory restrictions on the advertising of medicines, 100 per cent of them see treasury ministers in this light too.

"Which one of the following statements would you chose to most describe your attitude? (A) If a contagious disease threatens Britain, I would trust politicians and government to be open from the start and to do the right things. (B) If a contagious disease threatens Britain, I do not believe politicians and government would be open from the start and to do the right things."		
Q.C19.	Attitude A	Attitude B
Newspaper health journalists	01	09
Electronic media health journalists	03	07
Health and social policy academics	03	07
Party political health spokesmen	08	02
Members of the H of C health select committee	04	06
Party political advisers on health and social policy	05	05
Senior civil servants	05	05
Health interest group representatives	02	08
Think tank policy experts	02	08
Senior medical and health professionals	01	09
	Totals 34	66

Question C19 stated: "Which one of the following statements would you chose to most describe your attitude? (A) If a contagious disease threatens Britain, I would trust politicians and government to be open from the start and to do the right things. (B) If a contagious disease threatens Britain, I do not believe politicians and government would be open from the start and to do the right things."

In response, a substantial 66 per cent chose option B and thereby expressed the view that if a contagious disease threatened Britain they would not trust politicians and government to be open from the start and to do the right things. Only a third of all respondents – 34 per cent – expressed the view that they would trust politicians and the government.

Significantly, 90 per cent of newspaper health journalists, 90 per cent of senior medical and health professionals, 80 per cent of think tank policy experts and 80 per cent of health interest group representatives all chose option B.

Only a majority of party political health spokesmen – 80 per cent – supported option A and in so doing expressed their view that politicians and government would be "open from the start and do the right things".

Both party political advisers on health and social policy academics and senior civil servants were equally divided with 50 per cent choosing A and 50 per cent choosing B.

Invited to give open-ended comment on the reasons for their answer one newspaper health journalist commented "not completely cynical, cock up rather than conspiracy". This view was again reflected amongst an electronic media health journalist who said "ignorance rather than malaise".

Across all respondent categories trust of politicians and government was low. Whilst some believed that by the nature of their work there would always be unintended consequences for politicians a clear majority believed that

government could not be trusted "political correctness is nonsense and the government are crap about rights", "this government lies, it is impossible to trust them", "while the Department of Health might be good, I would not trust the politicians", "I would not trust this lot, the lying is huge", "this government is not good with truth".

While some believed that often it is not always right for ministers to be open from the start of an outbreak - "wouldn't be open but might be the right thing to do, especially in [an] epidemic", "openness and doing the right thing can be competing" – just over a third were positive: "the Department of Health and the government machine are good with plans for this kind of crisis", "you can trust politicians and government but they wont necessarily get it all right", "they do their best, systems are in place for this", "the health and other ministries would do their best – of any party. They have good planning, expertise and people. They would do the correct thing". Interestingly, one person said: "in the past I would have said two. But now, I work in the department and know how things are done".

Question C20: Many people argue that because disease and epidemics can impact on everyone in society, politicians must be in charge of public health. What do you think?"

Moving on directly from question C19, C20 stated: "Many people argue that because disease and epidemics can impact on everyone in society, politicians must be in charge of public health. What do you think?"

In reply, most newspaper health journalists implicitly accepted a role for politicians to be in charge of public health: "agree, regulatory role, heard immunity [however there] could be more involvement of the private sector", "have to be in a democratically elected society", "public health is a legitimate government issue", "someone must be in charge, politicians are elected", "agree but not solely, could just coordinate", "legitimate coordination role", "need some sort of regulating role", "this is where public health meets

defence". Only three people fundamentally agree with the statement: "not necessarily", "providers could be private", "no, strongly disagree, would not trust politicians with total authority, small role in coordination and dissemination of information".

With the electronic media health journalists there was more general scepticism: "don't agree at all", "if you look at the government's approach to BSE and foot and mouth political and financial considerations get in the way of the best solutions", "not true, individuals are more educated than politicians think they are, individuals would make better choices than politicians". Alternatively some did see a role for politicians and government in this area: "agree, government is about making stable, successful, happy societies – something as basic as healthcare is a government duty", "there has to be a central overview of public health...politicians will always be involved in public health because of the way it is funded".

Health and social policy academics were again mixed. Supporting this role for politicians respondents said: "broadly agree", "yes in large measure a national response is needed as public health in the nineteenth century showed". One respondent even commented "genuine emergencies need emergency action. Otherwise politicians should have a very limited role in public health. For example, the Black Death is like going to war so you would not use peacetime measures. However, this rarely happens, so government should keep out of public health". Against the politicians, respondents asserted: "in an ideal world a more disinterested body would be in charge", "not necessarily politicians", "disagree, don't think that just because something has universal effects it needs government action". Again one respondent concluded: "public health is increasingly the rubric used by western political elites to justify the therapeutic state and a wide range of health fascist restrictions and bans on people's freedom and lifestyle choice. Healthcare is a natural private good. Public health in its statist sense is an abomination".

Party political health spokesmen were universally supportive of the idea: "agree – politicians and chief medical officer is a government responsibility",

"will have a role to play", "yes", "yes and their officials", "public health is a priority for government", "decisions on public health must be taken on a population level therefore ultimately parliament should oversee public health work", "there is a role for government in contagious disease". Not being able to perceive a market alternative one respondent concluded "yes, an unelected alternative is not good"."

Whilst some members of the House of Commons Health Select Committee supported the role of politicians – "common sense", "yes of course, not a question" – others added the caveat that such work should be lead by clinicians: "No, independent public health doctors should be in charge", "no, doctors, politicians must oversee the funding of a public health system [as] they are elected". Interestingly, one person commented "yes, but there is too much nannying" whilst another concluded "[there should be the] private delivery of [an] active strategy of public health".

One of the most mixed set of comments came from the party political advisers on health and social policy. Displaying a wide range of opinion they said: "yes, aspects should be politically managed", "politicians should have an important role but this should not amount to a monopoly", "patient groups should also have a role irrespective of government", "a role for politicians in public health is easier to defend than in other areas of healthcare", "don't agree", "has to be a politically accountable system, at present, politicians are the best as they are answerable to the people", "ultimately agree, public health equals public good", "to a certain extent, small role within reason", "don't agree at all, too simplistic, epidemics are usually regional not global", "national politicians get it wrong, management should be at regional and global levels – public and private too", "politicians must ensure universal and free at the point of delivery healthcare, does not need to be centralised, regional better to cope with regional needs".

Overall, 60 per cent of senior civil servants generally agreed: "ultimately, the health of the nation must have a strategic and supervisory role", "do need to have public health responsibilities, but the government could be in charge of

strategy", "it should not be left to the private sector", "you could argue that the state should concentrate on this and leave other healthcare alone", "public opinion will demand that they are". The other respondents in this category put forward alternative views: "no need to fund or provide", "not true", "not a must, other alternatives available", "not must".

Likewise, health interest group representatives were mixed in their responses: "largely true", "no certainly not, need informed professionals", "there is a clear political aspect", "agree that overall, state has public health responsibility", "politicians should not be in charge of anything", "agree", "strongly agree", "if politicians are advised by the medical profession then yes it is OK". Dividing up the various aspects of public health one respondent concluded: "charities and individuals have a role in keeping people healthy; however, there is a need for some sort of central coordinating body".

Significantly, most think tank policy experts disagreed with the statement in C20: "one does not need the state for vaccinations", "I disagree", "not necessarily", "disagree, down to individuals to be responsible because it impacts on all in society", "no, epidemics are rare things and the government track record in public health is not good". On the other side a couple of respondents said: "there is a political role for coordinating, but private bodies are better at dealing with outbreaks", "some truth, the Black Death is like a military attack", "there are some public health issues that may need government, for example, the use of the military in outbreaks".

Finally, senior medical and health professionals tended to see a role for politicians and government but were generally concerned with regulatory issues and the involvement of clinicians: "doctors must be in charge, totally independent from government", "ought to be given to pubic health experts and not politicised", "the government need to be there but not necessarily politicians", "not sure it has to be politicians, some sort of regulatory body", "a disasterous idea", "should not be run by politicians and should not be party dependent", "delivery no, need healthcare professionals and a national framework".

Question C21: How do you react to the following statement? The reason the poor and chronically sick are always neglected is because ever since Roman times, political elites in Britain have always sought to plan, control and regulate the provision of health services. Through the Roman military, then the church, the Royal Colleges, Parliament, and the timeless granting of legislative favour, the state has always sought to empire-build and to control people's access to healthcare and medicine."

Question C21, the final question of the survey, stated: "How do you react to the following statement? The reason the poor and chronically sick are always neglected is because ever since Roman times, political elites in Britain have always sought to plan, control and regulate the provision of health services. Through the Roman military, then the church, the Royal Colleges, Parliament, and the timeless granting of legislative favour, the state has always sought to empire-build and to control people's access to healthcare and medicine."

In reply, most newspaper health journalists agreed with the statement but added various caveats: "I am not quite so cynical, but element of truth", "true", "disagree", "some truth...state systems do serve the middle classes better", "probably do agree historically", "sympathetic by would not knee jerk agree", "exaggeration", "strongly agree, anecdotal evidence and record of government over the years shows this to be true however well intended".

Conversely, most electronic media health journalists, disagreed: "don't agree at all, they are neglected not because of control but due to education, environment and social conditions", "don't agree", "this credits the state and politicians with far too much ability to control populations, I believe in cock up rather than conspiracy, the state has been unable to care for the poor and chronically sick but not by design", "disagree", "disagree, various politicians attempted to expand healthcare beyond the elite", "don't know, parts may be true", "I dont believe they are always neglected". A couple of respondents agreed with the statement in C21: "the powers that be have always sought to

influence healthcare as it affects people who vote for them, politicians have a more underhand influence than people understand", "parts may be true, poor get a worse deal by default, they are not articulate, cannot complain and their services are therefore not improved".

The health and social policy academics surveyed offered varying – yet often more in depth – responses: "big historical generalisation...generally the state does not have the capacity especially control over the church", "while not claiming that the state is always motivated to maximise social welfare, reliance, mainly on private institutions (as in the USA) tends to exclude the poor even more strongly...this is not an attack on private delivery of healthcare but on reliance mainly on private finance", "don't agree fully with this historical analogy, the medieval period was a great mixture of provision and the types of medicine...need to look at much wider social factors", "to an extent true, money and power gets the foot in the door to health". In addition the supportive responses, "agree" and "agree with that" one respondent concluded: "this statement is totally true because it focuses on the central question of power in society. From tribes in pre-history to the modern world, the chiefs and monarchs of the state have always granted monopolistic and legislative favour to the would-be monopolists of the day. Throughout the ages medical professionals, through the church and then parliament, have always sought state power and sold it in the name of the public good. As such, there has never been a necessary divorce between healthcare and political power. Throughout history, there has never been a genuine market in health provision. As such, the poor and chronically sick – the socially powerless – have always suffered. They have been marginalised and suffered at the hands of the public good".

Similarly, the party political health spokesmen had firm views: "something in that, inclined to agree", "completely over the top", "not sure, I don't really know", "not sure, never thought of this, sounds interesting", "more than a grain of truth about controlling access and empire building of the state, can apply to modern times but not sure historically", "nonsense, far more complicated", "not sure I do agree". One Member of Parliament concluded: "not

characterised by state control. [The problem is a] lack of health provision overall. People were developing private arrangements before the NHS. Poor people have no market power, so they are left with a state system and are grateful for what they get...Not sure about the church...since the advent of the welfare state, the inevitable price of state intervention is state control".

Members of the House of Commons Health Select Committee tended to either hesitantly support the statement in C21 or steer a cautious middling path: "not sure", "not sure government has always been so involved", "this is mudding the state with the churches and the colleges", "sounds good", "sounds too simplistic but interesting", "there is always an issue of elite control, but elites can help the poor too", "healthcare demands government acting for us all", "elites have always oppressed the poor, but this is the fault of classes and power not the state".

Party political advisers on health and social policy tended to express positive support: "agree", "elements are true, but too universal", "agree strongly", "some elements of truth, but not universally, true in twentieth century", "very interesting, broadly agree, people and elites pursue their own power". Only one person strongly disagreed: "completely disagree. Politicians have created universal and free system that has given the poor the first ever access to healthcare. Healthcare can be provided by the private sector, but only to assist the state sector."

While most senior civil servants surveyed tended to agree – "partly true", "yes", "agree", "states try to control costs", "pretty cool" – others were more critical: "do not agree", "don't really agree, don't think [the state] is anti-poor", "strongly disagree, political intervention aims at equality of access, their failure is neither here nor there".

The health interest group representatives were split down the middle: "elements of truth", "couldn't disagree", "probably partly true", "agree", "the reason for neglect of poor and sick is because the state has not learnt from private sector marketing". On the other side: "disagree despite criticism, the

state has not sought to empire build or neglect, the state model is more likely to protect the poor", "this is silly, there is an argument that the state is not good at healthcare provision but the NHS removed fear and dread of the poor for doctors and medical bills; healthcare is a human right, not a whim of the market or largesse of the rich". Interestingly one respondent concluded: "absolutely agreed up to the first Labour government, now definately not since the introduction of the NHS".

A clear majority – 80 per cent – of the think tank policy experts surveyed strongly agreed: "radical enthusiasm for this statement, problem has been worse since world war two", "strongly agree", "partly agree", "quite true, but not whole truth", "broadly agree", "true, agree with spirit, interest groups do bend NHS to their own benefit", "has to be true, nature of regulation; UK never had true alternative so therefore people are not fully trusting of the private sector". Conversely, other respondents concluded: "nonsense, tirade", "I don't agree that the poor always miss out but there is unnecessary control in healthcare".

Finally, senior medical and health professionals presented a wide range of responses: "don't agree with the first part as the NHS spends loads on the poor", "prefer to think that despite some politicisation of healthcare some people/politicians have genuinely wanted and attempted to improve healthcare of all", "it is a cynical view that actually it is too expensive to provide adequate healthcare, but if government had enough money they would do it", "access is controlled but not sure that this is why the poor and chronically sick are neglected, it is often a lack of education amongst the poor that leads to neglect rather and intention", "agree", "agree, this has evolved although this is not what was set out to be done", "true, but not sure the state has sought to deliberately restrict access", "sometimes the poor and chronically sick are helped by the state", "don't agree that the poor always miss out but there is unnecessary control in healthcare", "probably relevant at the time; the church now has less impact but have been replaced by other interests over time".

CHAPTER VII

FROM BIG GOVERNMENT TO CONSUMERISM: THE LIMITS AND BOUNDARIES OF CORPORATIST DISCOURSE IN HEALTHCARE

This chapter provides an overview of the major research findings. In highlighting the constraints and weaknesses of current thinking amongst health opinion formers, it contextualises the limits and boundaries of the respondent's views. In exploring the respondents' notions of market failure, political failure, monopoly, consumer ignorance, neglect of the poor and chronically sick, externalities, public goods, private goods, the perverse incentives of insurance, and the moral hazards of state welfare, the current limits and parameters of thinking are exposed and examined.

Comparative Overview of the Research Findings

Q.A1. "If a real market in healthcare existed, Government would still have to intervene to stop problems of Monopoly.
Average 5.9
Q.B8. "If a system of real state healthcare existed, a market providing people with choices would still have to be allowed to stop problems of Monopoly."
Average 6.9

Overall, the research found that while respondents were somewhat neutral towards the statement "if a real market in healthcare existed, Government would still have to intervene to stop problems of monopoly" (5.9), they tended to agree with the countervailing view (6.9) that:

> "if a system of real state healthcare existed, a market providing people with choices would still have to be allowed to stop problems of monopoly".

With more respondents unsure about notions of monopoly being associated with a real market in healthcare (however they interpreted the notion 'real market'), the findings suggest that they believe that under a system of real

state healthcare (again, however, they interpreted this) a market providing people with choice would still have to be allowed to stop problems of monopoly. There is a sense perhaps that some kind of market and choice mechanism are inevitable preconditions to any viable healthcare system.

Whether this erring on the side of the laissez faire market is the result of the current debate on the NHS or a broader scepticism about the theoretical limitations of state healthcare, however, remains unclear.

What is clear is that when it comes to the notion of monopoly in state and market driven healthcare systems the market currently tends to be seen as being slightly less problematic. The market is perhaps seen in terms of being a slightly better check on monopoly power than the state.

Q.A2 "If a real market in healthcare existed, Government would still have to intervene to provide objective information to overcome problems of Consumer Ignorance".
Average 5.8
Q.B9. "If a system of real state healthcare existed, people would have to be allowed to access a wide range of competing health information so that individuals could overcome the problems of Consumer Ignorance."
Average 8.1

Likewise, the research found that while respondents were somewhat neutral towards the statement "if a real market in healthcare existed, Government would still have to intervene to provide objective information to overcome problems of consumer ignorance (5.8) they strongly supported the countervailing view (8.1) that:

> "If a system of real state healthcare existed, people would have to be allowed to access a wide range of competing health information so that individuals could overcome the problems of consumer ignorance".

With most respondents questioning the benefits and even perhaps the notion of objective government information for healthcare consumers, the research

found that under a system of real state healthcare (however conceived) a market providing people access to a wide range of competing health information would still have to exist so that people could overcome the problems of consumer ignorance.

As such, there is a sense that some kind of market in health information is inevitable and/or desirable. Whether the system in question is state or market driven government information is viewed with a greater degree of scepticism. Choice is seen as a means by which individuals can overcome the problems of informational consumer ignorance.

Q.A3 "If a real market in healthcare existed, Government would still have to intervene to protect the Poor and Chronically Sick from Neglect."
Average 7.3
Q.B10. "If a system of real state healthcare existed, there would still be a need for many private healthcare charities and groups to protect the Poor and Chronically Sick from Neglect."
Average 6.7

The research found that while respondents were somewhat supportive of the view that "if a system of real state healthcare existed, there would still be a need for many private healthcare charities and groups to protect the poor and chronically sick from neglect" (6.7), the respondents were even more supportive of the statement (7.3):

> "If a real market in healthcare existed, Government would still have to intervene to protect the Poor and Chronically Sick from Neglect."

Significantly, when seeking to protect the poor and chronically sick from neglect, respondents seemed to both accept a role for private healthcare institutions under state healthcare and a role for government healthcare institutions under a market system.

Overall, respondents tended to see both systems as containing checks and balances for the other. Perhaps chiming with the rhetoric and agenda of public

private partnerships, the opinion formers surveyed no longer hold the view that the state should or could attempt to 'do it all'.

The stereotypical view of the 1940s that the NHS will provide all healthcare for everyone is no longer seen as appropriate - or even possible. When it comes to the poor and chronically sick, there is a general acceptance of a role both for private and state healthcare.

Q.A4. "If a real market in healthcare existed, Government would still have to intervene to help protect people from such external factors as contagious disease."	
Average	7.6
Q.B11. "If a system of real state healthcare existed, private healthcare would still have to intervene to help protect people from such external factors as contagious disease."	
Average	4.1

The research found that while respondents were somewhat sceptical of the statement "if a system of real state healthcare existed, private healthcare would have to intervene to help protect people from such external factors as contagious disease" (4.1), they were much more supportive of the view (7.6) that:

> "If a real market in healthcare existed, Government would still have to intervene to help protect people from such external factors as contagious disease".

With such a wide cleavage (3.5) and a positive score for the statist perspective of (7.6) it is clear that not only are most respondents sceptical about the free market's capacity to respond to contagious disease but that most people see this as an area which demands direct government coordination and intervention.

Overall, respondents appear to be distrustful of the idea that a free market could generate the institutional means by which the principles of the good of the herd could be protected over and above that of the individual.

Q.A5. "If a real market in healthcare existed, this would not stop some of it being run by government because healthcare is a natural public good."	
Overall Average	5.1
Q.B12. "If a system of real state healthcare existed, this would not stop some of it being run by a private market because healthcare is a natural private good."	
Overall Average	6.3

Overall, the research found that respondents were neutral towards the statement "if a real market in healthcare existed, this would not stop some of it being run by government because healthcare is a natural public good" (5.1). Instead, they cautiously supported the view (6.3):

> "if a system of real state healthcare existed, this would not stop some of it being run by a private market because healthcare is a natural private good."

With a cleavage of just 1.2 and a consensus that generally accepts healthcare has both having private and public goods characteristics the respondents tended to see both systems as containing checks and balances for the other.

Again chiming with the contemporary rhetoric and agenda of public private partnerships in healthcare, the opinion formers surveyed no longer hold the view, prevalent in the late 1940s, that the state could or should provide all healthcare for everyone.

Indeed, both extremes were seen by the respondents as being problematic and as having profound limitations.

Q.A6. "Because people's healthcare is unpredictable some of its costs will always have to be covered by government – private arrangements such as insurance cannot do it all."	
Overall Average	6.2
Q.B13. "Because people's healthcare is unpredictable some of its costs will always have to be covered by private healthcare – government arrangements such as taxation cannot do it all."	
Overall Average	6.6

Looking at the issue of insurance and taxation, the research found that while respondents were very marginally supportive of the statement, "because people's healthcare is unpredictable some of its costs will always have to be covered by government – private arrangements such as insurance cannot do it all", they were only slightly more positive towards the view (6.6) that:

> "Because people's healthcare is unpredictable some of its costs will always have to be covered by private healthcare – government arrangements such as taxation cannot do it all."

Although the cleavage between the two groups was narrow at only 0.4 and both groups were only marginally positive with their scores there is nevertheless a clear pattern emerging. While respondents accept a role for government healthcare there is also a general agreement that "government arrangements such as taxation cannot do it all".

Whereas in the late 1940s one might have expected more respondents to have accepted the view that market based systems such as insurance cannot 'do it all' today's opinion formers are slightly more sceptical of this historic and statist position.

This is not to say that the respondents are in anyway confident in or supportive of private medical insurance. Instead, the results just suggest that there is a tentative acceptance of a role for private medical insurance alongside tax funded healthcare.

Q.A7. "If people are covered by private healthcare, there is a greater incentive for them to use it and get their money's worth."	
Overall Average	6.0
Q.B14. "If people are covered by state healthcare, there is a greater incentive for them to use it and 'get their money's worth'."	
Overall Average	6.6

Looking at the issue of private health and taxation, the research found that while respondents were only marginally supportive of the statement, "If people are covered by private healthcare, there is a greater incentive for them to use it and get their money's worth" they were slightly more positive towards the view (6.6) that:

> "If people are covered by state healthcare, there is a greater incentive for them to use it and 'get their money's worth".

Although the cleavage between the two groups was very narrow at only 0.6, and both groups were only marginally positive with their scores, there is nevertheless a clear pattern emerging. While respondents accept a role for government there is also a general agreement that "government does not have all the answers".

In a limited way the NHS is perhaps viewed as providing perverse incentives. Because it is funded from general taxation and 'free' at the point of use there is more incentive for patients to use its services and to 'get their money's worth'.

Question C15: In Healthcare, what would be the consequences of a genuine, private, market system?"
Question C16: "In Healthcare, what would be the consequences of a genuine, full blown, state system?"

Concerning questions C15 and C16 it is interesting to note that many of the points made against a genuine, private, market in healthcare are also made against a genuine, full blown, state system. Both are said to be: "inequitable", "two tier", "rationed" and "costly". Conversely, many of the positive points concerning a genuine private market system are also used to support a full blown state system: "efficient", "poor would do better", "more cost effective".

While state healthcare was generally viewed as utopian, bureaucratic and requiring higher taxes, the market is generally differentiated in terms of encouraging innovation, better information and greater personal responsibility.

Overall, respondents tended to favour public private partnerships, "thank god we have always had a private health sector that can now be exploited", and they also favoured regulation to "ensure fairness". Significantly, only one respondent questioned the monopoly that currently underpins all systems of healthcare: "unless the problem of medical professional monopoly is dealt with [a genuine, private, market system would] be as inefficient as it is today".

Q.C17. "In healthcare, which is more prone to the problems of monopoly?."		
	The State	The Market
Totals	82	18

Given the probing question: "in healthcare, which is more prone to the problems of monopoly, the state or the market?", 82 per cent of respondents chose the state.

Building on the questions A1 (If a real market in healthcare existed, Government would still have to intervene to stop problems of Monopoly) and

B8 (If a system of real state healthcare existed, a market providing people with choices would still have to be allowed to stop problems of Monopoly), the response to C17 makes it clear that, under pressure and with no opportunity for a graduated response, an overwhelming majority of respondents see the problems of monopoly power as being more associated with the state than the market.

This is interesting not least because it chimes with the position held by the radical advocates of the free market Austrian school of economics that true monopolies only exist because of state intervention. In the words of the Ludwig von Mises Institute:

> "Economists of the classical school were right to define a monopoly as a government-grant privilege, for gaining legal rights to be a preferred producer is the only way to maintain a monopoly in a market setting. Predatory pricing cannot be sustained over the long haul, and not even the attempt should be regretted since it is a great benefit to consumers. Attempted cartel-type behaviour typically collapses, and where it does not, it serves a market function. The term "monopoly price" has no effective meaning in real market settings, which are not snapshots in time but processes of change. A market society needs no antitrust policy at all; indeed, the state is the very source of the remaining monopolies we see in education, law, courts, and other areas."[1]

Q.C18. "In healthcare, which two of the following four groups has most to gain from statutory restrictions on the advertising of medicines?"				
	Medical Professionals	Private health bosses	Treasury Ministers	Consumers
Totals	61	29	81	29

Building on previous questions concerning information to patients (A2 "if a real market in healthcare existed, government would still have to intervene to provide objective information to overcome problems of consumer ignorance" and B9 "if a system of real state healthcare existed, people would have to be

[1] See more on the Austrian Economics Forum at: http://austrianforum.com/index.php?showtopic=419

allowed to access a wide range of competing health information so that individuals could overcome the problems of consumer ignorance."), C18 asked: "in healthcare, which two of the following four groups has most to gain from statutory restrictions on the advertising of medicines – 1. medical professionals, 2. private health bosses, 3. treasury ministers and 4. consumers?"

Importantly, an overwhelming majority of respondents - 81 per cent - saw treasury ministers as having the most to gain from the statutory restrictions on the advertising of medicines. Again, a majority - 61 per cent - also identified medical professionals as generally benefiting from such restrictions.

Identifying the cost containment pressures on treasury and other government ministers, the respondents clearly believe that censorship is used by politicians to stem consumer power and therefore demand. Similarly, far from wanting to empower healthcare consumers with an open market in information, respondents seem suspicious of the medical profession and its desire to control and censor. Only a minority of respondents - 29 per cent - believe that there would be any benefit for private healthcare bosses or consumers to have restricted access to health information – in this case the advertising of medicines. As such, the opinion formers surveyed seem to believe that government is rationing healthcare supply and information and that to preserve their own power and status doctors are complicit in this venture.

Question C19: Which one of the following statements would you chose to most describe your attitude? (A) If a contagious disease threatens Britain, I would trust politicians and government to be open from the start and to do the right things. (B) If a contagious disease threatens Britain, I do not believe politicians and government would be open from the start and to do the right things."		
	Attitude A	Attitude B
Totals	34	66

As stated in the previous chapter, in response to the question if a contagious disease threatened Britain respondents would trust – or not trust – "politicians

and government to be open from the start and to do the right things" a substantial 66 per cent chose the negative (option B). Only a third of respondents – 34 per cent – expressed the positive view (option A).

Whilst most people who chose to comment tended to distrust politicians (and where highly critical of a perceived culture of spin and untruthfulness) many tended towards the "cock up rather than conspiracy" perspective. They were concerned with the unintended consequences of political action. Importantly, a number of people pointed out that openness was not always consonant with "doing the right thing".

Question C20: Many people argue that because disease and epidemics can impact on everyone in society, politicians must be in charge of public health. What do you think?"

Turning to the issue of externalities question C20 asked "many people argue that because disease and epidemics can impact on everyone in society, politicians must be in charge of public health. What do you think?"

In response, while a majority of respondents accepted a role for politicians to be in charge of public health, many added the caveat they should involve other experts such as clinicians. At the extreme, several respondents likened a contagious disease outbreak to a war: "this is where public health meets defence".

Alternatively, a small number of respondents focused on a broader definition of public health and attacked politician's interventions in people's lifestyle choices: "public health is increasingly the rubric used by western political elites to justify the therapeutic state and a wide range of health fascist restrictions and bans on people's freedom and lifestyle choice. Healthcare is a natural private good. Public health in its statist sense is an abomination".

Only an extreme minority said that politicians and the state should have no role in the public health of epidemics: "don't think that just because something has universal effects it needs government action". Not being able to perceive a market alternative one respondent concluded "yes, an unelected alternative is not good"."

Question C21: How do you react to the following statement? "The reason the poor and chronically sick are always neglected is because ever since Roman times, political elites in Britain have always sought to plan, control and regulate the provision of health services. Through the Roman military, then the church, the Royal Colleges, Parliament, and the timeless granting of legislative favour, the state has always sought to empire-build and to control people's access to healthcare and medicine."

In response to the statement: "the reason the poor and chronically sick are always neglected is because ever since Roman times, political elites in Britain have always sought to plan, control and regulate the provision of health services. Through the Roman military, then the church, the Royal Colleges, Parliament, and the timeless granting of legislative favour, the state has always sought to empire-build and to control people's access to healthcare and medicine" the 100 opinion formers surveyed were divided.

While a number questioned the history presented – particularly the medieval period - some clearly agreed with the general proposition that healthcare has always fallen under the purview of elite power by various forms of legislative favour. While 40 per cent of those surveyed disagreed with the statement, 50 per cent expressed a positive or sympathetic response. That said, a significant minority of respondents – some 10 per cent - confessed to not having thought about healthcare in terms of societal and elite power.

CHAPTER VIII

CONCLUSION: POLITICS, COERCION AND POWER - AN ANALYSIS OF ECONOMIC FAILURE IN HEALTHCARE SYSTEMS

This study has examined notions of government and market failure in British healthcare by tracking and analysing the changing views of opinion formers. In presenting its research findings it has highlighted the attitudes of today's opinion formers towards populist notions of health economics and has provided insights into the limits and boundaries of contemporary debate.

Significantly, it has shown that substantial swathes of elite opinion no longer support the National Health Service (NHS) in its traditional – fully nationalised - form. Instead, a majority of opinion formers now believe in a much greater role for private healthcare – although they remain sceptical of a purist libertarian position. Overall, the average British opinion forming respondent believes the following.

Looking at private funding arrangements versus the state, a majority of the opinion formers surveyed believe that because people's healthcare is unpredictable, some of its costs will always have to be covered by private healthcare – "government arrangements such as taxation cannot do it all". Perhaps mindful of the pressures on the NHS and contributions made by a wide range of health and social care charities, most respondents believe that the state cannot cover the costs of unlimited healthcare.

That said, the average respondent also believes that if a real market in healthcare existed government would still have to intervene to protect the poor and chronically sick from neglect.

Indeed, the opinion formers believe that many of the points that can be made against state healthcare can also made against private healthcare. Recognising the inevitability of scarce resources, both systems are thought to be 'inequitable', 'two tier', 'rationed' and 'costly'.

For respondents, many of the positive points concerning private healthcare are also used to support a state system. Both are seen as being potentially 'efficient', 'helping the poor to do better' and ultimately 'more cost effective'. That said, while the average respondent sees full blown state healthcare as being 'utopian', 'bureaucratic' and requiring 'higher taxes', the market is generally thought superior at harnessing 'innovation', providing 'better information' and encouraging 'greater personal responsibility'.

Significantly, the average respondent tends to favour public private partnerships but does not equate the concept of monopoly with the monopoly power of the medical and other healthcare professions. Indeed, very few respondents seem to appreciate that healthcare, irrespective of sector, is ultimately predicated upon the legislative favour of government through the professions.

Most respondents tend to believe that if a system of real state healthcare existed, a market providing people with choices would still have to be allowed to stop problems of monopoly. Chiming with the principles of libertarian orthodoxy, they tend to see state healthcare as being a much greater monopolist than the market.

Most opinion formers support the view that if a system of real state healthcare existed, people would have to be allowed access to a wide range of competing health information so that individuals could overcome the problems of consumer ignorance. Wary of the state control of information a majority side with the principles of the open society and reject state censorship.

Again, sensitive and hostile to governmental cost containment measures respondents identify treasury ministers and medical professionals as benefiting from the statutory restrictions on the advertising of medicines.

The average respondent believes that if a real market in healthcare existed, government would still have to intervene to help protect people from such

external factors as contagious disease. However, at the same time, they tend not to trust politicians and government to be "open from the start and to do the right things". On this latter point, 'cock up' tends to be most opinion formers preferred view of government - not conspiracy.

In response to the statement, "many people argue that because disease and epidemics can impact on everyone in society, politicians must be in charge of public health", the average respondent accepts the role for politicians and/or the state but they tend to add the caveat that other experts, such as clinicians, should be fully involved. Providing medical, health and security professionals have an appropriate input, few respondents object to politicians and the state intervening in times of epidemic or national emergency.

The average respondent views healthcare as being a natural private good – not a pubic good as often argued in many academic text books.

The average respondent believes that if people are covered by state healthcare, there is a greater incentive for them to use it and "get their money's worth".

Overall, the average respondent tends to view state healthcare as providing perverse incentives. They tend to believe that more healthcare will be unnecessarily consumed under a state system than in a market system.

Finally, the average opinion former tends to be uncertain when it comes to the idea that through the granting of legislative favour, the state has always sought to empire-build and to control people's access to healthcare and medicine. There is a general belief that history is more complex than this – although there is also a willingness to accept that the NHS benefits the middle classes more than the poorest and most disadvantaged in society.

Overall, these results show that the world has moved on significantly since the heady days of the 1940s. Today, there is not only greater understanding of the failure of state healthcare – and a more balanced approach towards the

appropriate role of markets – but there is also an awareness of the problems of producer capture.

In its traditional, fully nationalised, mode the NHS enjoys little support amongst opinion formers. Having much less faith in the authority of top down direction than previous generations there is a clear acceptance of markets and a key role for consumers.

That being said, while the overall debate remains dominated by corporatist notions of public private partnerships, there is only very marginal support for a genuine libertarian market in healthcare – if any at all.

Today, as with most other historic phases in the development of medicine and healthcare, the overwhelming majority of opinion formers believe that there is an important role (however loosely defined) for government.

It is clear from the results generated that the state is seen by opinion formers to be the ultimate guarantor of communitarian safety in times of biological or chemical attack. It is also seen as a vital institutional nexus responsible for the setting of professional standards and the enforcement of contract.

In the contemporary healthcare debate, while the utopian statism of the early NHS now finds little favour, the more fundamental rubrics legitimating state intervention remain. Not only do the limits and boundaries of contemporary policy conversation recognise a role for state intervention but, as with defence, intelligence and policing, healthcare is viewed as an integral part of a wider and almost timeless political order.

However strident and popular ideas of market driven healthcare might become in the years ahead there is, as yet, no serious constituency amongst opinion formers that truly questions the grander and statist narrative underpinning the discourse of healthcare and the sector's professionals.

As with the markets that flourished in healthcare during the Middle Ages and the nineteenth century, the ultimate rubrics of statism remain largely unchallenged in their institutional and moral senses. However powerful free market consumerism might become in the future, a residual acceptance of state power provides the intellectual platform upon which legislative favour can be inexorably sought and perpetuated.

In many ways healthcare has always been a deeply corporatist venture run in association with a range of mystical, military, religious, or purely political, state elites: the forces Ayn Rand categorised as the witch doctor and Attila. Yet, as in all previous eras, politics, state coercion and power not only seem set to remain entwined with the affairs of healthcare but the modern biomedical paradigm appears to be firmly bound by its discourse and constraints.

In the future, as opinion formers perhaps continue to adjust back to a broader acceptance of independent healthcare provision and funding, one is therefore unlikely to hear demands for a truly radical shake up of healthcare – even from the private sector itself.

Instead, all the indications suggest that the key players in British healthcare will continue to prefer gradual and incremental reform. Mindful of their vested interests and the views of other opinion formers they will shun the re-ordering anarchy of truly a dynamic and competitive health market in favour of a more limited and conservative approach. As with the worlds of defence, intelligence and policing the stage is set in healthcare for the continued perpetuation of a corporatist agenda that slowly transcends the stereotypical boundaries of public versus private, regulation versus brand reputation and left versus right.

As the twenty first century opens up before us a clear majority of opinion formers might no longer believe in the NHS but they still firmly believe in important roles for the state. When it comes to economic failure in healthcare systems, politics, coercion and power seem set to remain key ingredients long into the future.

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