

The Politics of Ideology vs. the Reality of Politics: The Case of Britain's National Health Service in the 1980s

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IN 1979 THE BRITISH PEOPLE ELECTED A GOVERNMENT which explicitly and emphatically repudiated the basis of the post-war political consensus. Mrs. Thatcher's government, like President Reagan's administration, sought to present itself as a crusading movement dedicated to breaking with the past. "The years of make-believe and false optimism are over. It is time for a new beginning," the 1979 manifesto proclaimed (Conservative Party 1979). The scope of government would be cut back. Taxes would be reduced. The new-style Conservative government would help people "to help themselves." Welfare services would be concentrated on "the effective support of the old, the sick, the disabled and those who are in real need," while in social security the emphasis would be on restoring the incentives to work.

The new approach not only marked a break with the preceding Labour government. Much more significantly, it also marked a break with the stance of previous post-war Conservative governments. Thatcher Conservatism not only repudiated the paternalistic corporate policies of the Macmillan era, 1958–1964, with their emphasis on involving employers and trade unions in the planning of economic strategy. It also repudiated the managerialist policies of the Heath government,

1970–1974, with their emphasis on government intervention to make the economy more efficient. The Thatcher program was shaped by a deep distrust of government as such. The role of government, it was argued, was not to do things for people. It was to create an environment in which people could do things for themselves. Individual decisions in the economic market place, rather than collective decisions in the political market place, should shape the allocation of resources. So government spending would be cut, in order to allow people to choose for themselves as to how to spend their money. New policies would be shaped by a new ideology.

This paper examines the impact of the Conservative government—returned to office by the British voters in the 1983 election—on the development of health policies in Britain. For Britain offers an almost paradigmatic opportunity for examining the relationship between party ideology and health care policy. For just as the Thatcher government represented a deliberate and explicit break with the past so the National Health Service (NHS) represents a monument to the post-war British consensus. If indeed there is a direct or immediate relationship between party ideology and policy outputs, it should be evident in health care policy developments in Britain in the years since 1979.

Ideology, Beliefs, and Assumptions

Before plunging into the analysis it is important to seek some clarity about the conceptual tools deployed. The term “ideology” is often used pejoratively. The implicit message tends to be that only extremists are ideologists, while sensible people in the middle of the political spectrum are pragmatists. In this paper, however, ideology will be used neutrally to describe the bundle of beliefs which all policy actors, in all policy arenas, carry with them. The term is not used to imply, necessarily, that these beliefs add up to a cast-iron, coherent system. In short, the ideology is used as rough and ready shorthand for the “appreciative system” (Vickers 1965, 69) of the policy actors. Such an appreciative system, Vickers points out, has two components: value judgments and reality judgments. That is, the system includes beliefs not only about what *ought* to happen but also about feasibility. Thus, when Conservatives in Britain argue that people should help themselves instead of looking to government to help them, this implies that

those concerned—the unemployed, for example?—actually are able to act autonomously. It is a statement both about the desirability and the possibility of certain actions.

The further assumption in this paper is that ideologies, in the wide sense here stipulated, are not the monopoly of political parties. Other sets of policy actors also have their ideologies or appreciative systems. Within the health care policy arena, for example, it is possible to identify the ideology of the medical profession or that of the corporate rationalizers (Alford 1975), that is, health care administrators and planners. We are, therefore, dealing with a constellation of ideologies, of which party ideologies are only part.

Lastly, it is helpful to draw a distinction between the ideologies of specific sets of policy actors (some of whom will be members of political parties, while others will be members of professional or organizational groups) and the prevailing public philosophy. By this is meant “an outlook on public affairs which is accepted within a nation by a wide coalition and which serves to give definition to problems and direction to government policies dealing with them” (Beer 1965, 5). The public philosophy is not necessarily explicit. On the contrary, the assumptions built into it may be significant precisely for what they take for granted and for what is ruled out of court automatically and without argument. But it is this public philosophy which defines the boundaries of political consensus (or overlap between party ideologies) and the acceptability of policy aims and means.

The Historical Legacy

Historically, Britain’s National Health Service is the child of a marriage of convenience between social engineers and social idealists, between the values of efficiency and equity. Its creation in 1948 marked the confluence of two movements which had their beginnings at the start of the twentieth century. First, there was the gradually evolving consensus that some form of national health service was both desirable and necessary in order to promote national efficiency (Gilbert 1966; Searle 1971). Cutting across the political parties, bringing together the bureaucratic and medical elites, there was a demand that the nation’s resources of scientific expertise should be rationally organized

and mobilized in order to make the population healthier and, therefore, more productive. Second, there was the growing insistence—particularly associated with the Labour party but by no means its monopoly—that a comprehensive and free health service was required in order to ensure social justice. The reason for taking medicine out of the market place, it was argued, was to promote equity. In other words, equal treatment should be available for equal medical needs, irrespective of the ability to pay.

The way in which these two sets of values combined to create the ideological foundations of the NHS can be illustrated from the speech made by Aneurin Bevan, the Labour minister responsible, when he first introduced the legislation for setting it up (Bevan 1946). On the one hand, he justified his plans in the language of social justice. "A person ought to be able to receive medical and hospital help without being involved in financial anxiety," he argued. Furthermore, the aim should be to "universalise the best" and to ensure the same standard of service to "every citizen in this country." On the other hand, he was equally eloquent in defining his proposals on the grounds that they would promote efficiency. The creation of a national health service would allow the hospital system to be rationalized by eliminating wasteful competition, overlap, and inadequate small institutions. "Although I am not myself a devotee of bigness for bigness sake," Bevan remarked in a celebrated phrase, "I would rather be kept alive in the efficient if cold altruism of a large hospital than expire in a gush of warm sympathy in a small one."

The creation of the NHS thus reflected a revolt as much against social irrationality as against social injustice (Eckstein 1958; Klein 1983a). Furthermore, its founding ideology was based on the assumption that, in the case of health care, efficiency and equity march hand in hand rather than, as is sometimes argued (Okun 1975), pulling against each other. For the social engineers and the social idealists shared the same faith in paternalistic expertise. If medical science could indeed produce a healthier and, therefore, more productive population—the prevailing belief (Fox 1984)—then both efficiency and equity demanded widening access to health care. Indeed, increasing social equity, in terms of access, would promote national efficiency, in terms of a healthier population. Thus, the Beveridge Report, which laid out the blueprint for the post-war Welfare State, assumed that the creation of a health service would pay for itself, since the "development of

the service' would lead to "a reduction in the number of cases requiring it" (Beveridge 1942, 105).

As far as the social engineers were concerned, it was necessary to create something like the NHS in order to give the experts—i.e., the medical profession—scope for deploying their knowledge and skills. From their perspective, the NHS would allow resources to be planned and deployed rationally by the experts, so as to maximize the impact of medical science. Similarly, the social idealists also looked to the experts. Equity demanded not only that the financial barriers to access should be torn down but that, once the patient had entered the health care system, resources should be allocated according to need. Someone, therefore, had to be responsible for defining needs and determining who was to get what. Once again, therefore, the role of the experts—i.e., the medical profession—was central. The fact that, as Bevan pointed out in his 1946 speech, the NHS provided "a greater degree of professional representation than any other scheme I have seen" did not reflect merely the organizational strength of the doctors but also the ideological foundations of the service. It institutionalized paternalistic expertise not so much because of the power of the medical profession but because of faith in the power of medical science.

It is precisely this emphasis on creating an instrument for the deployment of paternalistic expertise, rather than a system of health care responsive to consumer demands (whether articulated through the political or the economic market), which makes the NHS unique in the Western world. In comprehensive but pluralistic health care systems, like Germany's or France's, demands are mediated by a variety of sickness funds. Even in a near-monopoly system, like Sweden's, control is devolved to local government. But, consistent with its founding ideology, Britain's NHS is designed to insulate decisions from either individual or political demands so that they may be taken according to rational criteria based on scientific or professional knowledge. Consequently, it divorces political decisions about the NHS's total budget from professional decisions about the allocation of resources to individual patients. The budget is set annually by central government; the use of resources, however, is determined at the periphery by doctors who are subject to neither audit nor review procedures. While countries like the United States, which have open-ended financial commitments,

insist on elaborate exercises in accountability, Britain's NHS offers almost total autonomy to doctors.

The ideological foundations of the NHS can, however, only be fully understood in the wider context of the prevailing British public philosophy of government. In particular, the belief in paternalistic expertise was part of a long political tradition which brought together Fabian reformers like the Webbs, Liberals like Beveridge, and Tories like Joseph and Neville Chamberlain. Those who subscribed to this view may have belonged to different political parties but they shared a common faith in the powers of expertise, if rationally organized in suitable institutions, and a common disdain for policies produced by the political market place. It was a tradition closely linked, moreover, to the "corporatist bias" (Beer 1965; Middlemas 1979) in British politics, with its suspicion of competition, its reliance on a strong civil service, and its belief in elite consensus engineering. It is, therefore, perhaps no accident that both the vocabulary and the institutions of the Welfare State were born in Britain. In no other country has the link between welfare and its provision by the state been taken as quite so axiomatic (Robson 1976). While other countries, like Germany or France, developed welfare societies, it was Britain which evolved the Welfare State—and which, in 1946, rejected the option of a comprehensive, free but pluralistic health system in favor of a *national* service.

For the first 30 years or so of the NHS's existence, the prevailing public philosophy and the ideology of the NHS were consistent and mutually reinforcing. These were, very broadly, the decades when it appeared that managerial policies were replacing party politics. The overlap between the partisan ideologies of the Labour and the Conservative parties—symbolized by the latter's acceptance of the institutions of the Welfare State created by the former—produced a large area of consensus in political debate. The contest between the Labour and Conservative parties revolved largely around the issue of which could establish its claim to superior management of the economy, and deliver a higher rate of economic growth to the voters. Labour tended to stress equity issues, while the Conservatives tended to emphasize efficiency issues. Similarly, while the former stressed the merits of bureaucratic planning, the latter stressed the advantages of the market. Overall, however, the NHS remained cocooned within this wider

consensus—a monument to Britain's national public philosophy—and consequently insulated from political controversy.

This is not to suggest, of course, that there was no evolution or no controversy in the health care policy arena during these years. But, for the most part, changes were in line with shifts of emphasis in the prevailing public philosophy. For example, the 1974 reorganization of the NHS by a Conservative government marked both the triumph of the managerialism which characterized the 1960s and a ritual genuflection in the direction of the consumerism which was to grow in strength during the rest of the decade. In line with the managerialist philosophy which had already reshaped the organization of both local and central government, the 1974 model NHS was designed to facilitate rational planning by means of a hierarchic chain of command: from central government to region, from region to area, and from area to district. At the same time, the 1974 model introduced Community Health Councils which were designed to provide a voice for local interests, although they were given no role in the decision-making process. Neither of these changes challenged the prevailing consensus. On the contrary, it was precisely the strength of the prevailing consensus which both constrained conflict within the NHS and limited the policy options which appeared on the agenda for debate. For example, the appreciative system of the policy makers assumed that any change in the basis of general practice in Britain would not be feasible on the grounds that it would produce an unacceptable level of conflict with the medical profession. So, during the whole history of the NHS, there has been no fundamental alteration to the system of general practice first set up in 1913 and taken over in 1948.

This era of overarching consensus has now ended both for the British polity as a whole and for the politics of health care. The 1980s can be characterized as a period of ideological polarization between the political parties in which the area of overlap between them, defining the national consensus, has shrunk. At the same time, the differences between interest groups in Britain have widened, thus leading to a more confrontational style of politics. The relatively bland politics of economic growth, when the dividends of growth meant that everyone could have something extra, have given way to the zero-sum politics of economic recession, as growing unemployment generates extra demands on shrinking or stationary resources.

The explicit challenge to the inherited public philosophy by the incoming Thatcher government in 1979, and its aggressive assertion that it represented a new political ideology, were noted at the beginning of this paper. But while the symbolic importance of this new political rhetoric needs to be recognized, it is important not to exaggerate or oversimplify. It would be misleading to suggest that the incoming 1979 Conservative government brought with it a coherent ideological program in its luggage. Once again, it would be more accurate to talk about an ideological *bias*. The point emerges clearly from the extremely cautious Conservative pronouncements in the 1979 manifesto about the NHS. First, the Conservatives pledged themselves to maintain spending on the NHS. Second, they proposed "to make better use of what resources are available" by simplifying and decentralizing the service and cutting back bureaucracy. Third, they announced their intention of ending "Labour's vendetta against the private health sector." Lastly, and extremely tentatively, they raised the possibility—no more—of examining possible changes in the basis of financing health care.

For Labour, however, even these cautious commitments constituted a threat to the NHS. "We reject Tory plans to create two health services: one for the rich, financed by private insurance, with a second-class service for the rest of us," the 1979 manifesto proclaimed (Labour Party 1979). The party firmly took its stand on its traditional "belief in a comprehensive National Health Service for all our people." And its specific policy proposals combined equity and efficiency. Like the Conservatives, Labour was pledged to "streamline the bureaucratic and costly structure" of the NHS, although, unlike the Conservative manifesto, the Labour one gleefully pointed out that it was the 1974 Tory government which had created the structure. Unlike the Conservatives, too, Labour stressed the need for a "fairer share of health funds across the country." The Labour party thus emerged in 1979 as the upholder of the traditional consensus position on the NHS.

Apart from this confrontation between the two main political parties, it is also important to note a more general ideological fragmentation that has characterized the policy debate about health care in the 1980s. The Welfare State, as it developed in Britain, was very much the product of the "Growth State." In turn, the bankruptcy of the "Growth State" has led to increasing skepticism about many of the assumptions