The Politics of Modernization: Britain's National Health Service in the 1980s

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OR 40 YEARS FOLLOWING ITS CREATION IN 1948, Britain's National Health Service (NHS) institutionalized a particular vision of health care delivery. It was a remarkably stable model based on the values of rational, bureaucratic paternalism (Eckstein 1958; Fox 1986a; Klein 1989). The benefits of medical science were to be applied and distributed by the professional experts; funding and structure were, in turn, designed to give the greatest possible scope and autonomy to these experts, so allowing the twin objectives of universal coverage and financial control to be achieved. During these decades the NHS provided a ready-made text both for those who wanted to extol and those who sought to denounce "socialized medicine," since its experience could be used to illustrate the advantages of such a model in terms of equity and economy and its deficiencies in terms of insensitivity to consumer preferences and organizational inertia. Now, however, the 1948 model is in the process of transformation. The publication in January 1989 of the Government's White Paper on the NHS, *Working for Patients* (Secretaries of State for Health 1989a), hereinafter referred to as the Review, marked the beginning of a new era. It was presented by the Government as the embodiment of a new millenarian vision, a design for health care delivery in the twenty-first century which would marry old-style British ideals of social justice with new-style American ideas about competition, and combine capped budgets with consumer choice. It was

denounced by the political opposition as a revelation of the cloven
hoof of Thatcherism, signaling a betrayal of the principles of 1948.
Above all, it provoked the medical profession into a display of militant
anger not seen since Aneurin Bevan announced his plans for the NHS,
with the Council of the British Medical Association voting to launch
a public campaign against the Government's proposals on the grounds
that they would cause serious damage to patient care (*British Medical
Journal* 1989) and the editor of the *British Medical Journal* calling on
the Royal Colleges to unite with the rest of the profession in opposition
to attempts by the Minister of Health to steamroller through change
(Lock 1989).

As in the years leading up to 1948, the drama of confrontational
debate conceals a complex reality. For the Review embodies a paradox
in as much as it combines conservatism and radicalism. On the one
hand, it confirms the special status of the NHS as a protected species.
It reaffirms the principle of a tax-financed, universal, free-at-the-point-
of-delivery health service. In short, it underwrites the status quo as
far as the funding and structure of the NHS are concerned. On the
other hand, the Review puts forward a number of potentially far-
reaching proposals for change within the existing framework of the
NHS. Seen from the inside, and in particular from the perspective
of the medical profession, the NHS is in process of change unprec-
edented in its history. What we have, then, is the picture of an
institution where, behind the stately facade, the workmen are begin-
ning to gut the old building and to modernize it.

The next section briefly summarizes the main proposals of the
Review. It is the thesis of this article, however, that their significance
can only be understood if account is taken of previous history and
the wider context; our argument is that they are interesting, and
perhaps have implications beyond the British health care policy arena,
precisely because they reflect more general trends and influences than
those special either to the Thatcher Government or the NHS itself.
Accordingly, subsequent sections examine changes in the socioeco-
nomic structure of the United Kingdom since 1948, the style of the
Thatcher Government, health policies in the 1980s, and the events
leading up to the Review itself. We conclude by offering our inter-
pretation of the Review—and its intriguing mixture of conservatism
and radicalism—in the light of these considerations. Our contention

is that Britain's NHS is now in a state of dynamic instability where it is difficult to predict the eventual outcome, but that this reflects less an ideology of privatization or a move toward dismantling one of the foundation stones of Britain's Welfare State than an international trend toward imposing a managerial in place of a professional definition of efficiency and effectiveness in health care—and that, despite all the rhetoric of consumerism and competition, the Review represents in some respects at least the apotheosis of rational, bureaucratic paternalism.

A Manifesto for the 1990s

The Review can perhaps best be seen as a health care manifesto for the 1990s. For, unlike the reorganizations of 1974 and 1982, the 1989 Review does not propose any major changes in the administrative structure of the NHS (Ham 1989). It is, rather, a design for an evolving organization, intended to change the managerial and professional culture of the NHS through the 1990s. It is, furthermore, characterized by extreme vagueness about the detailed implementation of many of its notions despite the publication of a series of supplementary Working Papers (U.K. Secretaries of State for Health 1989b–i)—a vagueness which has incurred much criticism and skepticism, not least from the medical profession. Its proposals, however, can conveniently be put into two categories following the line of our analysis. In the first fall those proposals that are intended to strengthen the managerial grip over the NHS and thus challenge the British definition of medical autonomy as meaning immunity from scrutiny; these, as subsequent sections show, follow the policy lines sketched out earlier in the 1980s. In the second fall those proposals that are intended to sharpen competition and to give patients a greater choice; these, as we shall see, represent the controversially innovative aspect of the Review. We deal with each in turn, concentrating selectively on the main proposals in each category.

In future, there is to be a clear division between the representative political role and the managerial function in the NHS. Within the Department of Health itself, the distinction is to be symbolized by the creation of a NHS Policy Board chaired by the Secretary of State, whose role it will be to determine strategy and set objectives, and a

Management Executive chaired by the NHS's Chief Executive, whose function it will be to deal with "all operational matters." Similarly, the Regional and District Health Authorities (responsible for hospital and community services) and the Family Practitioner Committees (responsible for primary health care) are to become much more managerial bodies. Whereas Bevan in 1948 institutionalized the idea of professional and community representation in their membership, the 1989 Review proposes to appoint their members exclusively on the basis of the "skills and experience they can bring" to the task of management. In short, there is to be a much more exclusive line of hierarchical accountability running from central to local management, with no concession to professional or community accountability. Conversely, the Review introduces, much more explicitly than ever before, the notion of managerial scrutiny of clinical activity.

Most notably, clinical audit is to become generally institutionalized in the NHS, where until now there has been no compulsory machinery of review. Audit is to be a clinically led system of peer review. Management has to satisfy itself, however, that "appropriate remedial action is taken where audit results reveal problems" and may, when necessary, initiate an independent audit. The importance of this move toward managerial oversight, however indirect, is reinforced by two other proposed changes. First, consultant contracts are to be made more specific. There are to be job descriptions covering the responsibility of consultants "for the quality of their work, their use of resources, the extent of the services they provide for NHS patients and the time they devote to the NHS," so as to allow management to "monitor whether consultants are fulfilling their contractual obligations." Second, the system of distinction awards—introduced by Bevan as a way of buying off the opposition of the Royal Colleges (Pater 1981; Webster 1988)—is to be drastically altered. These awards, which at the top end of the scale may double a consultant's income, are at present handed out by an independent medical committee. They therefore reflect, and reinforce, professional definitions of merit. In future, both the composition of the committee and the criteria used to make the awards are to be changed. The committee's membership is to include managerial representation, and consultants will have to "demonstrate not only their clinical skills, but also a commitment to the management and development of the service" if they are to qualify.

Similar changes are proposed in the case of general practitioners and have already been embodied in a draft contract (U.K. Department of Health 1989) published shortly after the Review. Their scope is narrower but their significance is, if anything, greater given that general practitioners, unlike consultants, are independent contractors, not salaried employees of the NHS—a status which they have fought to retain for over 70 years. Here too, a system of medical audit is to be introduced. More specifically, there is to be an attempt to limit prescribing costs of general practitioners (GPs); an "indicative" drug budget is to be set for each GP practice which, over a period of time and with generous tolerances, it will be expected to achieve. Given other changes already in the pipeline (see below) the direction of policy in the case of primary health care—as in the case of the hospital and community services—is toward tighter managerial control.

The other theme of the Review is, as already noted, greater competition and greater choice. The aim is to make the NHS "more responsive to the needs of patients." The means is a move toward a NHS where the individual health authorities will be responsible for buying appropriate services for their populations rather than, as at present, providing those services themselves. Each will be given a budget, weighted to reflect the characteristics of its population. Each is then to be free (in theory) to buy appropriate services either from other health authorities or from the private sector. To promote competition between providers, the Review suggests two radical innovations. First, it proposes that NHS hospitals should be able to opt for independent, self-governing status. This would enable them to determine the pay and conditions of their staff, instead of being bound by national agreements as at present, and they would be free to borrow on the capital market. Their income would come from contracts with health authorities, which might be on a cost-per-case basis or cover a block of services (U.K. Secretaries of State for Health 1989b). The intellectual debt to Enthoven's (1985) notion of an "internal market" within the framework of the NHS is clear. Second, the Review proposes that large GP practices be given the opportunity of becoming "budget holders." That is, they are to be given a fixed budget, out of which they will be responsible for buying some of the services now provided free by NHS hospitals for their patients. These would include diagnostic tests and treatment for elective surgery, but not treatment for chronic conditions (U.K. Secretaries of State for Health 1989d).

GP budget holders will be free to refer their patients to any hospital of their choice. The presumption in all this is that competing for customers will make hospitals more sensitive to consumer preferences and the flexibility of the proposed system will help to dispose of the problem of waiting lists for elective surgery that has haunted the NHS since 1948.

It is not the main purpose of this article to pronounce on either the feasibility or the desirability of these proposals—although we touch on this in the concluding section. But, as has already been argued, the significance attached to the Review depends crucially on an understanding of the events leading up to its launch and to the socio-economic and political environment in which health policy has been developing in Britain in the 1980s. We, therefore, next turn to examining the latter.

The Changing Environment

In analyzing the NHS's environment, it is helpful to distinguish between underlying social, economic, and technological trends and the way in which Mrs. Thatcher's Government has chosen to respond to the resulting challenge of change. The trends themselves, of course, largely reflect slow movements in the glacier over decades. So, for example, the transformation of the British economy from its dependence on the traditional heavy industries to a service economy heavily reliant on information technology has been long in the making (Gershuny 1983), and is still far from complete. It is the sharpness of the perception of change, the growing awareness that a new kind of society was (for better or worse) emerging from the ruins of Britain's nineteenth-century industrial legacy, that increasingly marked the decade as it progressed toward its end. It was a transformation reflected in the politics of the 1980s, since the 1980s have been remarkable both for the domination of Mrs. Thatcher and for the attempts of other parties to rethink their own styles and politics. There is growing awareness, in the Labour as well as the centrist parties, that a new environment calls for a new kind of politics. Hence, it is important not to interpret the politics of the NHS (or indeed of any other policy area) simply in terms of the ideological preferences or idiosyncracies of Mrs. Thatcher's administration, but to see them as much as the

product of the forces which allowed her to win three elections in a row and kept her in office in the 1980s (Klein 1988).

The NHS was born into a largely working-class society only slowly emerging from war, where rationing and queueing were symbols not of inadequacy but of fairness in the distribution of scarce resources. It celebrated its fortieth anniversary in 1988 in what had become an affluent consumer society, where only access to work was rationed. Whereas in 1951 over 64 percent of the occupied population were manual workers, by 1981 the proportion had fallen to under 48 percent. Whereas in 1947 only 27 percent of the population owned their own homes, by 1981 the proportion had risen to 58 percent (Halsey 1988). It is a society, therefore, where an increasing number of people take it for granted that they control their own lives.

It would be a mistake, however, to imply that Britain has moved into the era of the politics of private consumption. Although Mrs. Thatcher was voted into office in 1979 on an antistate-spending platform, public support for welfare expenditure has grown in strength ever since—if selectively so, with strong support for the NHS, retirement pensions, and education, as against benefits for the unemployed, single parents, and children (Taylor-Gooby 1987). Moreover, public expenditure on welfare state programs has continued to increase throughout the period. Survey evidence suggests that "private welfare is seen as superior to state welfare on almost every count" but that support for privatization coexists with "countervailing sentiments of collectivism" (Taylor-Gooby 1986). Overall then, the picture that emerges is an untidy one, with crosscurrents, that suggests an unwillingness either to abandon traditional collective responsibilities or to embrace the new consumerism without reservation.

We do not know to what extent public attitudes are shaped by government policies, as distinct from government policies being a response to voter preferences. But it is clear that the Thatcher Government is committed to the principle that the market knows best, even though its practice has been more fitful and less consistent than its theory (Cavanagh 1987). If the NHS was born in a period of nationalization, it celebrated its fortieth birthday at a time when many of the industries which had been taken into state ownership in the 1940s were being sold off—notably electricity and gas—with the pace quickening as the 1980s progressed. The Thatcher administration's faith in market principles must not be equated, however, with

less government. If the scope of central government was reduced in some aspects, its tread became heavier. In a sense, the Conservative Government can be seen as the equivalent of the Tudor monarchy asserting the power of the state in order to modernize a country previously dominated by feudal barons and corporate interests. To deal with the groups that had created the sclerotic postwar consensus in support of their own interests (as the Tory revivalists saw it), the state had to use its authority to break them. It, therefore, needed more power, not less, if the corporate stalemate was to be broken and if Britain was to modernize its economy. The first Thatcher administration tackled and tamed the trade unions. The second Thatcher administration reduced the financial autonomy of local Government, turned its attention to the quasiprofessions, and demonstrated the impotence of university and school teachers to resist government policies designed to reshape the education system. Finally, the third Thatcher administration took on the professions; almost simultaneously with the publication of the NHS Review, it put out proposals for fusing the legal profession in Britain and thereby breaking the monopoly of courtroom advocacy enjoyed by barristers. In short, the implicit vision of society is that of a strong, centralized state and strong, individualistic consumers, but with the role of intermediary bodies—be they local authorities, trade unions, or professional associations—sharply diminished.

The changing philosophy of government implies, in turn, a different approach to the machinery of government. In its pursuit of efficiency, the Thatcher administration has resurrected the techniques, many of them imported from America, first developed in the 1960s and early 1970s by the rationalist managers. Its "Financial Management Initiative" (U.K. Prime Minister and Chancellor of the Exchequer 1983) transformed adminstrative style throughout Whitehall. It requires each department to set objectives and to monitor progress toward the goals set. Equally, the new philosophy implies shrinking the size of central government and transferring many of its functions to a variety of agencies employing their own staff (Jenkins, Caines, and Jackson 1988). In other words, the breakup of Whitehall is now on the agenda.

In pursuing a policy of strengthening central control over decision making while decentralizing activity, the Government is following some larger and cross-national trends particularly evident in the organization of manufacturing, retailing, and servicing industries. Gen-

erally, as predicted by Schon (1973) more than a decade and a half ago, the trend is from centralized institutions to networks, from hierarchic, top-down models of organization to looser constellations. This fragmentation of traditional hierarchic models has been made possible by developments in information technology and has, in turn, been accelerated by them. Given the rapid diffusion of knowledge, and given also the rapid pace of change, an adaptable peripheral learning model may be more appropriate and functional than a rigid central command model (Fox 1986b). And what goes for the private sector applies, if anything with greater force, to the public sector. Thus, it has been argued that "in a more complex environment top-down control becomes ineffective: instead the State becomes an overseer, a regulator of independent and competing organisations" (Mulgen 1988).

Such, then, are the main elements of the transformation of the environment in which the NHS operates. The puzzle addressed in the rest of this article is, therefore, not just how and why the NHS has changed but also how far and why the NHS has been insulated from the environmental pressures which have engulfed other institutions. Why has the NHS survived Thatcherite iconoclasm in the 1980s? Why has public support for it remained so strong? To answer these questions we first look at the process by which the Government sought to mold the NHS in its own values in the 1980s, before the publication of the 1989 Review.

Health Policy in the 1980s

In broad terms, four themes emerge from the history of the NHS in the 1980s. First, contrary to the rhetoric of the 1979 general election manifesto, but in line with the more general drift of government policy, there was a sharp turn towards centralization. Far from devolving responsibility and thereby diffusing blame, the Department of Health and Social Security moved toward setting objectives and monitoring progress toward their achievement. Second, and linked to this, there was a revival of faith in managerialism and bureaucratic rationality, again marking a change of emphasis from the start of the 1980s and a return (albeit unacknowledged and with variations) to many of the ideas fashionable in the 1960s and early 1970s. Third,

there was a continuing, if unspectacular, expansion in the private sector and in the contracting out of services from the NHS, in line with the initiatives taken in the early 1980s. Fourth, there was a growing emphasis on the development of primary health care and prevention, as part of a wider strategy designed to stress the role of the consumer in exercising choice and responsibility.

The Return to Centralization

The 1979 manifesto commitment to decentralization was faithfully carried into effect by Mrs. Thatcher's first Secretary of State, Patrick (subsequently Lord) Jenkin. The 1982 reorganization of the NHS represented a policy of diffusing blame by pushing responsibility to the periphery (Klein 1985). But no sooner had the policy been implemented than it was reversed by Jenkin's successor, Norman Fowler, who took office in 1983 and remained there until 1987. The style of the Department of Health quickly changed. From repudiating the language of norm setting and insisting that health authorities must have freedom to make their own decisions within broad national guidelines, the Department greatly tightened its system for controlling health authorities. A system of performance indicators, designed to compare the activities and costs of different authorities, was introduced (Pollitt 1985). Specific targets were set to authorities who, for example, might be required to increase their output of hip replacement or cataract operations (Day and Klein 1985a). And the various instruments of control were brought together in the annual review system. Under this, the performance of each region is annually reviewed at "accountability meetings" between ministers and regional chairmen; in turn, the regions review the performance of each district; finally, each district reviews the performance of its subunits (U.K. Department of Health and Social Security n.d.). In short, there is a hierarchy of review and accountability running from the individual hospital to the Secretary of State.

A number of factors help to explain this drift to centralization. First, it reflected the overall administrative style of the Thatcher administration, with its emphasis on setting objectives and achieving greater value for money. Second, it was a reply to Parliamentary criticism (U.K. Social Services Committee 1981; U.K. Public Accounts Committee 1981) that the Department did not have an ade-

quate grip on how money was used at the periphery. Third, it was a response to the claim that the Government was being excessively niggardly toward the NHS (see next section), and the growing political salience throughout the 1980s of such issues as waiting lists for surgery. If ministers were to disprove the claim that the NHS was underfunded, and that services were inadequate as a result, they had every incentive to push health authorities into increasing their activities. In this respect, it is not just the revival of centralization that is significant. It was centralization speaking a different language. If in the 1970s priorities in the NHS were expressed in terms of inputs— so many beds, nurses and doctors— by the mid 1980s they were being expressed in terms of outputs—so many patients treated and so many operations carried out.

A New Management Style

In October 1983 there appeared a 25-page document which was to transform the management style of the NHS. This was the *Report of the NHS Management Inquiry,* led by Sir Roy (as he subseqently became) Griffiths, managing director of one of the country's most successful supermarket chains, Sainsbury's (Griffiths 1983). The style of the inquiry itself was to set the tone for its recommendations. It involved only four people. It took a mere six months to complete its tasks. It worked quickly and informally, consulting a great many people but not formally taking evidence. It thus marked a break with the tradition of setting up Committees and Royal Commissions, representative of all the interested parties, whose job it was to produce acceptable consensus reports—a break which has, more generally, been one of the hallmarks of the Thatcher administration. The new management style in the NHS was thus born of an equally new approach to decision making in government—brisk and decisive, if sometimes also peremptory—and mirrored many of those characteristics.

The Griffiths Report's analysis was not new. The NHS was suffering from "institutionalised stagnation"; health authorities were being "swamped with directives without being given direction"; the NHS was an organization in which it was "extremely difficult to achieve change"; consensus decision making led to "long delays in the management process." In short, the report concluded in a phrase that was to reverberate through the media and across the years: "If Florence

Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge." From this diagnosis followed a clear prescription: a general management structure from the top to the bottom of the NHS—i.e., individuals, at all levels, responsible for making things happen. At the top, within the Department of Health and Social Security (DHSS), there was to be a Supervisory Board to be chaired by the Secretary of State to set objectives, take strategic decisions, and receive reports on performance; below that, still within the Department, there was to be a Management Board led by a Chief Executive to carry out the policy objectives, provide leadership, and control performance; lastly, and perhaps most importantly, there were then to be general managers responsible for the operations of the NHS at all levels—regions, districts, and units. The general managers, the report suggested, might well be recruited from outside the NHS or the civil service, while their pay and terms of service should be linked to their performance.

The recommendations were carried out almost to the letter. Both a Supervisory and a Management Board were set up within the DHSS, an arrangement which, however, was to prove unstable. Within the NHS, however, the general management revolution swept on. Everywhere, at every level, new managers were appointed: some brought in from industry, commerce, and the armed services but primarily old-style administrators reborn as managers, with a sprinkling of nurses and doctors. The consensus district management teams born in 1974 effectively died ten years later, and with them the attempt to institutionalize producer syndicalism—predictably so, given the Government's general suspicion of corporate interest groups. The mobilization of consent for change, rather than the consolidation of consensus, became the new style (Day and Klein 1983). In effect, the medical and nursing representatives on the management team lost their veto power.

A revolution in management style did not mean an immediate transformation of the NHS. The effects have depended much on individual personalities and the local environment, and may take a further decade or so to work themselves through the system. But for many managers, the effects were liberating (Strong and Robinson 1988). There was an increase in confidence and a greater willingness to reject the claim of NHS providers—porters or nurses or consul-

tants—that they were autonomous in their own spheres and accordingly immune from scrutiny. The new style of management was, therefore, potentially subversive of the traditional position of consultants. If managers had output targets to meet, and if they were to be judged by their relative position on the national performance indicators, they had no alternative but to challenge consultants. For it is consultants who decide in the NHS about how resources are used—for example, the number of cases treated by individual orthopedic surgeons varies five-fold from 200 to 1,000 a year (Yates 1987). It would be misleading to imply, however, that the post-Griffiths era produced a direct confrontation between managers and clinicians. One theme of the Griffiths Report was precisely the need to engage clinicians in management. The process has been more subtle than a direct challenge or confrontation. In a sense, the threat of managerial scrutiny may have been more important than its reality, to the extent that it persuaded the medical profession itself to examine, if only defensively, its own practices.

Other factors were also pushing the medical profession in the same direction, factors which reflected wider changes in the NHS's environment. In particular, patients in the NHS services were becoming more like consumers in the market place in one respect. Given dissatisfaction with the product, they were more likely to seek redress from the law (Ham et al. 1988), contrary to the British tradition. The Medical Protection Society reported an increase in the number of claims of medical negligence received, from 1,000 in 1983 to over 2,000 in 1987; the Medical Defence Union, the other major provider of insurance for doctors, reported a similar trend. At the same time the courts considerably increased the size of the awards made. The result was a sharp increase in defense society subscription rates: from £95 a year in 1980 to £1,080 in 1988. If Britain was still a long way from an American-scale "malpractice crisis," the country seemed to be traveling in the same direction. No wonder, then, that there was also growing interest in the medical profession in American-style quality-assurance programs designed to make sure that the product met required standards.

In all this there is an irony. This is that much of the impetus for the increased emphasis on standards came from a report which explicitly took private, for-profit, management as its model. In a sense, the NHS—which since its birth has been dominated by the belief

that its "publicness," its immunity from the corrupting effect of profit seeking, would guarantee high quality to the customer—has been forced to reassess this assumption, and to recognize, if only implicitly, that it is a myth. It is a process that has been further accelerated by the growth of the private sector, to which we next turn.

A Drift to Privatization

Perhaps the most significant aspect of the growth in the private sector of acute medical care in the 1980s for the purposes of this analysis is that it was consumer and supplier led rather than Government led. Despite the rhetorical invocation of the benefits of the private sector in its 1979 manifesto, the Government introduced only very minor tax concessions. It did, however, permit even full-time NHS consultants to carry out some private practice. And, between 1979 and 1988 there was an increase of 50 percent in the number of beds in private hospitals, from 6,600 to 10,370 (Independent Hospitals Association 1988); during the same period, the proportion of the population covered by private health insurance rose from 5 to nearly 10 percent (Laing 1988). Moreover, the private sector remains highly specialized. Its main business is providing elective repair surgery for those conditions where there are waiting lists in the NHS; thus, an estimated 16.7 percent of all nonabortion elective surgery in England and Wales was carried out in the private sector in 1986 (Nichol, Beeby, and Williams 1989a, 1989b). It offers treatment to improve the quality of life for people of working age rather than coping with life-threatening conditions for the population as a whole.

The growth of the private sector appears largely to reflect changes in the socioeconomic environment, in particular the preferences of a more affluent consumer society. Unsurprisingly, both insurance coverage and private health-services use follow social class, and are largely a function of income (U.K. Office of Population Censuses and Surveys 1984; Propper and Eastwood 1989). Most important, and crucial for understanding the context of health policy making in the 1980s, there is little evidence that the growth of the private sector reflects any general disillusion with the NHS as distinct from dissatisfaction with specific aspects. There is little correlation between the demand for private health care and the supply of NHS services locally; demand

is highest in the London regions, which also have the highest level of NHS provision—precisely what would be predicted if population and employment characteristics are the decisive factor. Moreover, even among those with private insurance coverage, more than one-half the inpatient stays and four-fifths of the outpatient attendances are made under the NHS.

It is not surprising, therefore, that the growth of the private sector has not eroded political support for the NHS, which has remained rock solid throughout the 1980s. The consumers do not exit into the private sector; they commute between it and the NHS, shopping around for the best bargain. As a result, neither voice nor loyalty is weakened. Indeed, it may well be that experience of the private sector *reinforces* precisely those pressures on the Government to which the 1989 Review was a partial response. The available evidence (Horne 1986) suggests that the growth of the private sector reflects a demand for consumer control over the timing of an operation, over who does the operation, and over the physical environment as much as frustrated access. In short, the semantic revolution in health care which has transformed passive patients (people to whom things are done) into active consumers (people searching out what the market offers) reflects the fact that, increasingly, men and women want to choose the timing of their treatment and the consultant who is to carry out the operation—goods not on offer in the NHS.

The growth of the private acute sector has had a further effect on the configuration of the health policy arena in Britain. It has, if anything, reinforced the support of the medical profession for the NHS. Private hospitals have had their problems; in 1987 occupancy levels were down to 55 percent and profits have at times been hard to make. The insurance companies have become increasingly preoccupied with cost containment as expenditure and subscription rates have soared; the basic, family subscription rates of Britain's largest insurer, British United Providential Association (BUPA), rose by 186 percent between 1980 and 1987, compared to a 52 percent rise in the retail price index (Laing et al. 1988). But the medical profession has enjoyed the dividends of growth without any such worries. In 1979 the insurance companies paid out under £37 million in medical fees; by 1987 this figure had topped £200 million (Laing 1988). In short, a situation where the NHS copes with the high-risk, high-cost

sections of the population and provides a salaried base for consultants who can then supplement their income in the private sector is very much in the collective interests of the medical profession.

The growth of the private sector in long-term care for the elderly can be dealt with more briefly. Here the expansion has, if anything, been more rapid (Laing 1988). In contrast to the acute sector, where independent providers account for only a small proportion of total health care, the private and voluntary sector had overtaken the public sector as the largest producer of institutional long-stay care for the elderly by 1987. However, it was neither consumer nor Government led. Rather, it was the result of a Government blunder, an example of the unintended policy effect. In an attempt to slow down the growth of social security expenditure on people in long-stay homes, the Government changed the rules governing payments. As a result, what had been previously low-visibility discretionary payments turned overnight into highly visible entitlements (Day and Klein 1987). Expenditure soared and is now running at a rate of one billion pounds a year. To underline the fact that this was an accidental and perverse policy outcome, rather than an attempt to encourage the private sector in line with Conservative philosophy, the Government has ever since sought ways of wriggling out of its commitment.

So, the growth of private long-stay care for the elderly, and the relative decline of the public sector, points to no simple ideological moral. But it once again underlines the importance of socioeconomic factors in explaining what happens within the health care policy arena. Given the increase in the population aged over 75, demand for institutional care might have been expected to rise irrespective of public policy. Given the fact that an increasing proportion of the elderly were becoming reasonably well-off, often with capital in the shape of a house, demand for private institutional care might have been expected to rise even if the public sector had been more generously financed. Further, the story illustrates how developments in the private sector feed back into the public sector. In the case of institutional care for the elderly, the growth of the private sector provoked fears that vulnerable elderly people would be exploited by proprietors anxious only to maximize profits. The result was legislation in 1984 tightening up the responsibilities of health and local authorities for maintaining standards in nursing and residential homes: i.e., for regulating the private sector (Day and Klein 1985b). But paradoxi-

cally, the consequent debate about regulation raised, in turn, questions about the extent to which the NHS was maintaining standards for the vulnerable elderly in its care—hence, adding to the pressure for improving quality noted earlier. If exploitation for profit is frequently perceived to be the original sin of the private sector, exploitation of patients by providers is often revealed as the original sin of the public sector (Martin 1984; Day, Klein, and Tipping 1988).

The introduction of competitive tendering in the NHS in 1983 would, at first sight, seem to provide a more clear-cut example of policy being shaped by the Government's new style and ideological stance. In September 1983 the DHSS decreed that cleaning, laundry, and catering services should be put out to competitive tender; these account for roughly 12 percent of the NHS's total expenditure (Ascher 1987). It was very much a central Government directive specifying precisely the procedures to be followed, the criteria to be met, and timetable to be followed. In its execution the introduction of con-tracting-out thus provides a neat case study of centralization at work, with ministers making it very clear that they were determined to push their policies through, whatever the resistance among NHS staff and health authority members.

In the outcome, there was both resistance and skepticism. In par-ticular, the principle of competitive tendering was seen as a direct threat by the NHS unions, National Union of Public Employees (NUPE) and Confederation of Health Service Employees (COHSE), which had been leading actors in the battle over private practice in the 1970s (Klein 1979). Moreover, it was intended as such; com-petitive tendering, in effect, challenged the virtual monopoly of the in-house providers of services. The fact that the Government suc-cessfully pushed its policy through, despite a national campaign by the unions and local attempts to block the tendering process, therefore illustrates the effect of changes in the NHS's environment on the balance of power within it. Developments in the NHS accurately reflect, in this respect, the general decline in the influence of the trade union movement. Similarly, the Government's insistence on compliance with its policy directive on competitive tendering clearly underlined its determination that national policy objectives must override local preferences. Health authorities which appeared to favor in-house tenders from their own staff were sharply dealt with.

The direct financial yield of the new policy turned out to be relatively modest. By 1986 annual savings had reached £86 million

(U.K. National Audit Office 1987). Furthermore, the policy did not "privatize" the NHS's support services in the sense of transferring them to the private sector. Of all the contracts awarded by the end of the first cycle of tendering in 1986, only 18 percent went to private contractors. The rest were all awarded to bids coming from in-house teams, which by the end of the period were capturing over 90 percent of all contracts. But if the direct effects were less than spectacular, the indirect effects were more significant. The exercise forced NHS managers to examine what they were doing. It demonstrated that change could be introduced and resistance could be overcome. Overall, then, the gains in efficiency may have been both larger and less visible than the figures of direct savings suggest. So, too, were the costs of the exercise which tended to fall on the lowest-paid and most vulnerable workers in the NHS. The price of successfully defending in-house services tended to be lower earnings and redundancies (Milne 1987). Overall, contracting-out is best seen as the product of an ideology of managerial efficiency, rather than of an ideology of privatization. It represents an attempt not so much to transfer the production of health care to the for-profit sector as to introduce some of the disciplines of competition into the NHS—one of the themes of the 1989 Review.

Controlling the Gatekeepers

One of the paradoxes of the NHS since its creation has been that it exercises least control over those who, in theory at least, exercise the greatest influence in determining the demand for health care: general practitioners (Day and Klein 1986). It remains unique in the special role and status given to GPs. They are, at one and the same time, the patient's agents in steering him or her to the appropriate specialist and the system's gatekeepers in that they determine who is referred where and for what. But they are also independent contractors. In effect, they are small businessmen who—as noted previously—have fiercely and successfully defended this status ever since 1913. Despite changes in the small print of the GP's contract—especially those introduced by the Family Doctor Charter of the 1960s—general practice has in effect remained an autonomous enclave within the NHS— a fact recognized by the 1982 decision to make Family Practitioner Committees, the bodies responsible for the administration of primary

health care, bodies independent of the NHS managerial structure and directly accountable to the DHSS. It was a decision that also reflected, as previously noted, the political costs of tangling with general practitioners; painful, ancestral memories of decades of wrangling with the British Medical Association (BMA) were slow to die in the DHSS.

But as the 1980s progressed, it became increasingly clear that the financial costs of avoiding a confrontation with the medical profession over general practice might outweigh the political costs. The emphasis on improved management in the hospital and community services might allow the NHS to cope with more demand within any given budget; the development of the private sector might provide a safety valve for excess demand. But none of these strategies could address the question of whether it was possible to limit the seemingly inexorable upward surge of demand itself. Was it inevitable, given the rise in the population aged over 75 and given the new possibilities of treatment opened up by technological change, that demand would go on rising? Or was it possible to devise other strategies which might at least limit the rate of expansion? As the questions became more urgent in the 1980s, so inevitably, attention turned to primary health care. This was a source of obvious concern for a Government anxious to control public spending. It represented an open-ended public expenditure commitment; there were no budgetary limits on the amount spent by GPs in prescribing, just as there appeared to be no way to control the costs they imposed on the hospital system by their referral practices. There were wide, seemingly inexplicable variations in the rate at which different GPs prescribed and referred—a range of 20 to one—yet, public policy seemed incapable of bringing discipline to apparent chaos.

Two miniature case studies, both anticipating many of the characteristics of the 1989 Review, illustrate the Government's strategy in tackling these issues. The first, the imposition in 1984 of limits on the right of general practitioners to prescribe what they wanted, provides a dress rehearsal of the style of the 1989 Review. The second, the publication of a comprehensive plan for the reform of primary health care, anticipates many of the contents of the Review.

The 1984 episode is significant chiefly for what it says about the Government's willingness to take on the medical profession, and its manner in so doing. The possibility of limiting prescribing—either to generic substitutes or to drugs found efficacious—had long been

discussed, but no formula acceptable to the medical profession (and the pharmaceutical industry) had been found. In November 1984, Kenneth Clarke—the Minister of State for Health, who was to be the Secretary of State for Health who launched the Review in 1989— simply announced a limited list (Wheatly 1985). The BMA, angered at the unprecedented failure of the Government to consult the medical profession before taking a policy decision, protested furiously. Eventually, compromise followed uproar: the limited list was extended from 30 to 100 items. But the Government had made its point. It had shown that its willingness to take on corporate interest groups could extend even to the medical profession and it had challenged the idea that clinical autonomy bestows the right to use public resources without scrutiny or limits.

The plans for reforming primary health care, first unveiled in 1986 (U.K. Secretary of State for Social Services 1986) and then produced in a revised form in 1987 (U.K. Secretary of State for Social Services 1987), were equally challenging. They had two main aims. The first was to strengthen managerial control over general practice. This was to be done by giving Family Practitioner Committees, hitherto managerial eunuchs, responsibility for carrying out a "regular appraisal of the quality and quantity of services provided," including rates of referral to hospital. The objective was to make general practitioners more sensitive to the preferences of their patients. This was to be done by increasing the capitation element in GP remuneration, by making it easier for patients to change doctors, and by providing more information about practices. In short, the aim was to create more of a market situation in which GPs would compete for the custom of patients. The Government stopped well short of embracing competition whole-heartedly, however. The Department of Health's plans said nothing about abolishing existing limitations on GPs to set up shop where they wished and about the right of existing practitioners to object to new entrants. Indeed, the Government even threatened to impose additional restrictions on the number of general practitioners allowed to practice, since extra recruits might mean additional referrals and more prescribing. As so often, the Government's enthusiasm for the principles of the market were constrained by its dedication to containing costs. For as the 1980s progressed, so money increasingly became the dominating issue in health politics—driving out other preoccupations and issues.

Götterdämmerung—and Back Again

In each decade of its existence the NHS has been afflicted by at least one crisis about money. In this respect the 1980s have been no different from the 1950s, the 1960s, and the 1970s. What distinguished the 1980s was that it appeared to be the terminal crisis. It was as though the history of the NHS were destined to be a remake of Wagner's Ring. There, be it remembered, the whole action of the four-opera cycle springs from a crucial moral flaw in the opening one when Wotan, the head god, acquires a hoard of gold by deception. It is this which provides the dramatic logic of the whole cycle, with the theme taken up in each of the operas, leading to the final conflagration in *Götterdämmerung*. In a sense, the history of the NHS could be written in much the same way, starting with the fact that the founding minister, Aneurin Bevan, failed to endow it with sufficient gold (Webster 1988) and that, as a consequence, the question of funding was destined to remain forever a matter of political feuding. And it would provide a neat climax if, at the end of the 1980s, the curtain had come down on the NHS in financial flames. Instead, as we shall see, there was to be no Götterdämmerung—but a final anticlimax as the firemen, led by Kenneth Clarke, the Secretary of State, rushed onto the stage to douse the fire with buckets of money in the last act.

It was a near-run thing. As the 1980s went on, so the chronically recurring financial crisis of the NHS appeared to become ever more acute. In discussing the reasons for this, the obvious starting point is the level of spending itself. Compared to the 1970s, the 1980s were years of financial stringency. Over the entire period from 1980–1981 to 1987–1988, current spending on the hospital and community health services rose by only 10 percent in real terms (U.K. Social Services Committee 1988a). It was a considerably slower rate of expansion than in the previous decade, although the decline in the annual increment had already begun in the second half of the 1970s. Even the technical question of how to calculate these figures—for example, what figures to use for the rate of inflation in NHS prices and wages—produced considerable controversy. For the purpose of this analysis, however, a more relevant focus than the odd disputed percentage point is the debate about how to interpret the expenditure figures that developed over the 1980s: the debate between the "in-

putters" and the "outputters," between the Government's critics and successive Secretaries of State.

The criticism of the Government's expenditure plans, as articulated by the all-party Social Services Committee of the House of Commons in a succession of reports, drew attention to a widening gap between the actual input of resources and what was required. To define what was required, the committee used criteria first devised in the 1970s by the DHSS itself in order to extract money from the Treasury. These produced an annual growth target of about two percent. As Barney Hayhoe, the then Minister of State for Health, (U.K. Social Services Committee 1986) put it in 1986:

> One per cent is needed to keep pace with the increasing number of elderly people: medical advance takes an additional 0.5 percent and a further 0.5 per cent is needed to make progress towards meeting the government's policy objectives (for example to improve renal services and develop community care).

Comparing actual spending levels with the expenditure needed to produce an annual growth rate of two percent, it was then a simple arithmetical exercise to produce a figure of the total underfunding of hospital and community services. Using this method, the Social Services Committee in 1986 produced a figure of £1.325 billion—i.e., about 10 percent of actual spending—as the cumulative underfunding since the start of the decade. It was a figure that was to reverberate throughout the entire debate, feeding alike the sense of grievance within the NHS and the indignation of Opposition politicians. And when the Social Services Committee repeated its exercise in 1988, it came up with the still more dramatic figure of £1.896 billion as the accumulated deficit.

The Government, in contrast, put the emphasis on outputs, i.e., on what the NHS was actually producing. For instance, it pointed out (U.K. Social Services Committee 1988a) that hip replacement operations increased from 44,800 to 53,000 between 1980 and 1988, while heart operations rose from 27,200 to 43,000. This, of course, was the logic of a value-for-money approach which inevitably hinges on the *relation* between inputs and outputs. But, while the Government's statistics could show improved productivity, they could not demonstrate adequacy of provision or quality of service. Given the

lack of any generally accepted measures of adequacy or quality, neither the case of the Government nor that of its critics could be proved or refuted. The demonstration of underfunding by the Social Services Committee was similarly flawed. The precise figure of the under-funding depended crucially on the baseline chosen. Yet, there was no particular logic about choosing 1980 as the starting point for the exercise; there is no way of telling whether the NHS was over- or underfunded in that year. So the deficit, as calculated by this method, could just as easily be twice as large or nonexistent. Finally, the method extrapolates into the future costs based on past practices at a time when it is public policy to change those patterns of service delivery.

The debate about the funding of the NHS turned out, not for the first time, to be a dialogue of the deaf. Lacking an agreed currency of discourse about such key concepts as adequacy, need, or quality, there was no way that agreement could emerge from the battle of statistics. And therein, precisely, lies the real significance of the debate. Its nature was defined less by the issues involved than by the characteristics of the NHS policy arena. In particular, it reflected the fact—as Enoch Powell (1966), a former Minister of Health, had pointed out 20 years before—that the medical profession has a vested interest in denigrating the NHS, that the best way of drumming up support for extra funding is to point to the service's shortcomings. In this respect, the 1980s are no different from previous decades. They differ, however, in the sheer ferocity of the confrontation in 1987 and 1988 between the Government and the medical and nursing professions.

The presidents of the Royal Colleges warned the country of im-pending disaster; the president of the Institute of Health Service Management called for a radical review of the NHS; the Committee of Vice Chancellors rumbled ominously about the threat of declining standards of medical education and research. Never before in the history of the NHS had there been such a public demonstration of concern, involving all the authoritative figures in the health care policy arena. Moreover, these concerns were dramatized almost daily in the newspaper headlines and television programs, which translated abstract questions about finance into human terms. There was a succession of reports about hospital wards which had to be closed because of cash shortages. There was a procession of consultants complaining about

being unable to carry out lifesaving operations because of lack of resources. There was a rash of strikes by nurses in protest about closures and shortages. The picture that emerged forcibly and vividly from all these accounts was that of a health service where the staff felt themselves to be unable to deliver care of adequate quality, where patients were being turned away, and where morale and standards were both plunging.

There was, of course, a case to be made on the other side. Low morale among doctors and nurses did not just reflect inadequate funding. It also reflected their sense of insecurity following the managerial changes discussed in the previous section; increasingly they appeared to be at risk of being challenged by managers seeking to increase output. Similarly, the national statistics about funding disguised wide variations in local experience. While some health districts were having their funding cut, as the Government's critics pointed out, others were notching up an annual growth rate of 5 percent in real terms (National Association of Health Authorities 1987). But given the obvious passion and conviction of the doctors and nurses prophesying the end of the NHS—a sort of apocalypse of shroud waving—such fine-print arguments did not carry much weight, any more than the statistics about the number of patients treated and of operations carried out. The Government bent under the pressure. First, in January 1988, came the Prime Minister's announcement of a review of the NHS. Second, there followed a succession of extra top-up grants to finance pay awards to doctors and nurses. Third, in July, Kenneth Clarke was appointed as the Secretary of State of a new Department of Health (shorn of its Social Security functions). He succeeded John Moore, who in his year at the DHSS, had signally failed to cope with the storm. Fourth, in November, the new Secretary of State announced that in the annual public expenditure round he had managed to extract an extra £1.8 billion for the NHS for the coming financial year—almost precisely the figure of "underfunding" produced earlier in the year by the Social Services Committee. The stage was set for the publication of the 1989 Review.

Toward a Self-inventing System?

Mrs. Thatcher's Review of the NHS was a private affair. In contrast to the Royal Commission on the National Health Service a decade

before (Merrison 1979), but very much in keeping with the Prime Minister's style, there was no attempt to create a consensus. The Review was, in effect, a three-ring circus revolving around Mrs. Thatcher herself, with ministerial, managerial, and medical working groups competing to generate options for her. But although the Review itself was private, its existence created much public excitement. In particular, it precipitated an intense flurry of pamphleteering (Brazier, Hutton, and Jeavons 1988). Almost everyone who had ever given a moment's thought to the NHS (and many who had not) rushed to publish their views on what ought to be done. Conservative ex-ministers, think tanks, professional and other pressure groups and academics, all joined in. The many and varied manifestos for change fell into two categories. First, there were variations on the theme of replacing a tax-financed by an insurance-based health care system. Second, there were proposals for improving the use of resources within the NHS by means of organizational change.

Both sets of proposals had one feature in common. They reflected the influence of American ideas and of the American notion that health care is a commodity rather than a public good. In the case of those who sought to replace the NHS by an insurance-based system, the influence was clear: the American model in the academic literature of market-based competition (Green 1988). In the case of those who sought organizational change within the framework of the NHS, it was again the impact of American ideas that was striking and, in particular, those of Alain Enthoven (1985). His advocacy of an "internal market" within the NHS, of health authorities buying and selling services to each other as well as to the private sector, in turn spawned a variety of other proposals—in particular, for health maintenance organizations which, again on the American model, would buy and sell services for those who subscribed to them. There appeared to be a terminal irony in the fact that, after 40 years which had brought a regular procession of Americans to Britain to find out the secrets of the NHS's success, the process was being reversed (Marmor 1988): the anorexic were seeking a cure from experts on obesity.

Long before the Government's Review was published, however, it became clear that there was no constituency for the more radical ideas being floated. Public support for the NHS did not fall, though worry about standards of services rose (*Health Service Journal* 1988)—predictably so, given the barrage of professional lamentations. The most popular view was that if the NHS needed more money, it should

come out of general taxation. The all-party U.K. Social Services Committee (1988b), having surveyed the various proposals on offer, came out in favor of cautious and experimental incrementalism. Above all, the medical profession—having raised the spectre of radical reform—took fright. The persistent and strident claims that the NHS was on the point of collapse quickly changed tone. In its evidence to the Government's Review, the BMA argued that only "a relatively small percentage increase in funding" was needed and that it would be "a serious mistake to embark on any major restructuring of the funding and delivery of health care in order to resolve the present difficulties" (*British Medical Journal* 1988). More eloquently still the BMA pointed out:

> While many of the alternative systems have shown superficially attractive features, we have always been led to the inescapable conclusion that the principles on which the NHS is based represent the most efficient way of providing a truly comprehensive health service, while at the same time ensuring the best value for money in terms of the quality of health care. They also enable the cost of health care to be controlled to a much greater extent than has been achieved with other systems, as has been shown by the experience of other countries.

The Government agreed. The Review, as we have seen, was notable for saying nothing about finance—a truly astonishing silence, given its origins. The funding of the NHS is not to be changed. The notion that private resources could, somehow, be tapped in order to relieve the pressure on public spending never took flight; there was no more than a symbolic nod in this direction, in the shape of tax concessions on insurance policies for the retired. But having decided that cost containment came first, and that there was no political constituency for radical change, the Review team was left with a dilemma. How could they satisfy the expectations (not least those of the Prime Minister herself) aroused by the exercise in the first place?

It is this dilemma that explains the paradox of the Review with which this article started: its blend of conservatism and radicalism. It is precisely because the Review endorsed the framework of health care in Britain created in 1948 that it was forced to seek radical ways of dealing with the pressures that had been mounting during the 1980s. In particular, it had to deal with two, mutually reinforcing,

sets of pressures that, as we have seen, provided the themes of policy making throughout the decade. First, there were the accelerating demands from the service providers to find more money for the NHS. These were translated by a cost-containment-conscious Government into pressure to increase productivity, and explain why much of the Review simply builds on the managerial development already in train. Second, there were the accelerating demands for services more responsive to consumer preferences, very much in line with the Prime Minister's philosophy, which explain the Review's attempts at radical innovation.

These two demands were mutually reinforcing in a new sense in the 1980s. For the events of the decade demonstrated the extent to which the NHS had previously been living off, and using up, the capital of inherited attitudes. For most of the history of the NHS, the medical profession, in return for exemption from scrutiny, had been prepared to disguise rationing decisions about the use of resources as clinical decisions about appropriate treatment (Aaron and Schwartz 1984). Similarly, patients had been prepared to defer to the professional judgment of doctors and to submit to the equity of the queue. In the 1980s it became clear that neither set of attitudes could any more be taken for granted. Challenged by managers, the willingness of doctors to take responsibility for rationing was wearing thin and their disposition to blame government was getting stronger. Equally, the transformation of patients into consumers meant that the democracy of the till was becoming more attractive for more people than the equity of the queue.

The response of the Government to these pressures, as reflected in the Review, owes more to pragmatic eclecticism than to conservative ideology. Consider, first, the managerial proposals. These, as our analysis of events in the 1980s show, mark the consolidation and logical extension of policies that were being developed throughout the decade. They represent, if anything, the ideology of Weberian bureaucratic rationality. They draw, moreover, on policy instruments devised in an era before disillusion with the state provision of welfare had crept in and when the challenge was seen to be to make public service more efficient. What is remarkable about the Review proposals in this respect (and what gives them their particular Thatcherite flavor) is the ruthlessness with which their logic has been pursued and previous political compromises jettisoned. If the NHS as it emerged in

1948 was largely a monument to the power of the lobbies—in particular, of the medical profession—this is clearly going to be much less true of the post-1989 health service.

On the face of it, the Review's proposals for more competition and more choice fit much more neatly into the mold of conservative ideology. These are certainly conservative "hurrah" words. But it is important to note the tensions within this set of proposals. So, for example, there is a basic ambiguity about the notion of the "internal market," of self-governing hospitals competing for custom. For whose custom are they competing? The answer is that they will be competing, chiefly, for the custom of district health authorities. It will be a managerial rather than a consumer market. Similarly, as already noted, the aim of forcing general practitioners to compete for the custom of consumers seems unlikely to be realized while tight restrictions remain on the number of doctors allowed to practice in any locality. In other words, whenever there is a possible conflict between containing costs and increasing choice, the Review invariably firmly comes down in favor of the former. Competition is seen primarily as a way of improving the efficiency with which resources are used within the existing framework of the NHS.

If the Review is no more than an uneasy compromise between competing objectives, if its main characteristic is its conservatism, why has it provoked a furor unprecedented since Bevan unveiled his plan for the creation of the NHS in 1946? There are two main reasons. The first has to do with the style of the exercise. If Clarke's Review has produced the same kind of apoplectic reactions from the medical profession as Bevan's NHS proposals, it is because there are remarkable similarities in the way the two men set about getting things done. If Clarke isn't quite a reincarnation of Bevan, he is the nearest thing to it that has been seen in 40 years. The second reason has to do with the uncertainty which the Review has created. If there is an apparently disproportionate degree of alarm, it is because the Review opens up a variety of futures rather than laying down a clear-cut predeterminate course. We elaborate each point in turn.

The presentation of the Review by the Secretary of State bears the hallmarks of an administration which believes, as the 1983 Griffiths Report argued, that the NHS suffers from an advanced case of institutionalized sclerosis—not surprisingly, perhaps, given that Sir Roy was one of Mrs. Thatcher's team of advisers. Kenneth Clarke put it

forward, therefore, as a plan of action, not as a document for discussion. It came complete with a timetable; so, for example, the first self-governing hospitals are to start operating in 1991. It is this which helps to explain the reaction of pained outrage from the medical profession. In a sense, the presentation of the Review was a reminder that times had changed, that the medical profession had lost its privileged status. The campaign by the BMA and the medical profession is, therefore, as much about the style of the Review as about its contents. To accept the style would be to accept also that the profession is no longer a fully fledged member of the gentleman's club that has hitherto run the NHS—that Mrs. Thatcher (who is no gentleman) is indeed dissolving the various clubs, even the City of London, that have dominated Britain in the past. No doubt there will be negotiations; no doubt there will be compromises; no doubt the Government will retreat on some of its proposals. But the tone, brisk and sometimes brusque, has been set.

Turning from style to content, the Review offers a field day for speculation. Specifically, the impact of the two most radical proposals, those for self-governing hospitals and GP budget holders, is contingent on the willingness of hospital staff and general practitioners to enter the new world of the medical market and to engage in that most unprofessional of all activities, competition. In turn, their willingness will depend on the availability of the information technology necessary for proper budgetary control (at present lacking in the NHS), and the likely balance of risks and incentives. No one knows, though many speculate, about the likely impact of allowing hospitals to fix their own salary levels; might not the result be (Robinson 1989) to push up NHS staffing costs? No one knows, though many speculate, whether the effect of the proposals will be to encourage the growth of the private sector or whether it will persuade NHS hospitals to engage in cutthroat competition (Laing 1989). Above all, no one knows whether independent hospitals and budget-holding GPs will eventually become the norm or whether these will remain experimental eccentrics. No one knows, too, the long-term effects of moving from a NHS based on trust to one based on contract, from a closed system of self-regulation by the professional providers to a more open system of audit with a strong managerial influence. Only one prediction seems reasonably safe. This is that, to the extent that Britain follows the United States, so the new era will benefit the middlemen of health

care: researchers, accountants, financial and management consultants, and others who profess expertise about efficiency even if they do not necessarily add to it.

The Review can, therefore, be seen as an exercise whose outcome no one, not even the Secretary of State, can predict. At this stage it is impossible to know whether change will be constrained by the framework of the NHS or whether it will eventually buckle the framework itself. Certainly the central tension in the NHS, which brought it so near to terminal crisis in the 1980s, remains: the tension between budgetary control and consumer demands. What the British Government appears to have created—whether by intention or inadvertence is not clear—is a situation in which the NHS will invent its own future in a process of trial and error. If in 1948 the NHS started life as an institution based on a clear-cut blueprint, it will enter the 1990s very much as an open learning organization designed to react flexibly to an uncertain environment.

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