The NHS After The Blair Experience – Healthier than Blair After the NHS Experience?

Introduction

This chapter explores whether there has been a distinctive New Labour health policy; what ‘modernisation’ has meant between 1997 and 2007; and what the legacy of ten years of Blairite government has been for the NHS: whether or not the NHS has been ‘transformed’, and what the balance sheet looks like in terms of successes and failures.

Given political devolution within the UK to a Scottish parliament and assemblies in Wales and Northern Ireland, the Blairite writ has run directly only in England. It may furthermore be debated whether or not the term New Labour, with or without Blair, applies outside England. Yet the UK outside England has often measured itself against England, whether from pride in difference, defiance or nervousness. And in health policy particularly, Blairite health advisers in England have often seen health reform in England as blazing a trail which the rest of the UK would do well to follow (a view partially rejected by the Scottish Labour administration before 2007, and wholly by the Scottish National Party administration elected that year.)

Consequently, while this chapter concentrates upon England, it does not ignore the rest of the UK – which is helpful in providing and additional perspective from which to view New Labour’s English NHS.

New Labour’s Inheritance

Despite having been in opposition for eighteen years, Labour’s health policy on assuming office in 1997 was sparse. Essentially, it was tactical, consisting in ‘we are not the Conservatives; we will save the NHS’ (for consumption by the audiences of the clinical professions and the general public) and ‘we will recognise our inheritance and avoid debilitating reform’ (for an audience of NHS managers, especially those high-flying Chief Executives which New Labour admired but who had tied their colours to the mast of Tory reform.)

Labour pledged to abolish the ‘internal market’ introduced in 1991 and ‘reintegrate the NHS without reorganisation.’ This was either contradictory or platitudinous: if there was a rampant internal market, abolishing it would require structural reorganisation; and if the internal market had already withered on the vine by 1997, then the policy was an inert one (a sheep in wolf’s clothing)……perhaps an acceptance of the ‘forces of conservatism’ which PM Tony Blair would excoriate in his party conference speech two-and-one-half years later in October 1999.

General New Labour Themes

As ever, it is important to situate health policy in its political context – politics IN health rather than (only) the particular politics OF health.
The overt part of the ideology of New Labour was derivative in two senses. Firstly, it was not based on values per se but derived from the dictates of political strategy. Secondly, this strategy was derived from the Clinton campaigns in the USA. The Blair ‘project’ sought to ‘triangulate’ between two polar opposites - defining itself by what it was not. Clinton had rejected not only Republicanism but also ‘traditional tax-and-spend Democratic policy’. The Blair project rejected not only (Thatcherite) Conservatism (at least on paper) but also the social democracy of what the Blairites were the first to call Old Labour.

Anything which was to the left of New Labour or based on the institutional interests of the Labour coalition was conveniently called Old. It was a short step in the world of spin, therefore, to adopt the word ‘modernisation’ as New Labour’s mantra. But, just as Herbert Morrison (a post-war Cabinet Minister and grandfather to the spinmeister of New Labour’s Peter Mandelson) had defined socialism as ‘what Labour governments do’, ‘modernisation’ could now be described as everything New Labour governments do - and everything that they disapproved was ‘old’ (whether Old Labour or – to try to keep the party faithful onside – the Old Tories.)

But modernisation also had a harder edge – it was not just the pragmatism, or opportunism, of Morrison in a modern setting. ‘Modernisation’ was part of the (initially) more covert part of New Labour ideology: it was at root a term alluding to political economy – in particular, the need for New Labour policy to conform to the dictates and constraints of capitalist globalisation. Thus the ‘forces of conservatism’ included not only ‘conservative’ social groups such as fox-hunters (and, more importantly, wider rural interests and ways-of-life) and those who were socially conservative but also (of course) the trade unions (Labour’s paymasters, past….and future, once Blair’s rattling of the box in the citadels of capitalism came to grief) and - even more significantly - all those who believed in, or were based in, national economic and welfare institutions which were in tension with the international market of global capitalism.

This was later to raise a particular conundrum for the NHS, when capitalist competition EU-style, on the one hand, and the penetration of global market forces WTO style, on the other hand, were to challenge the NATIONAL health service, a particular challenge in 2007 for new Prime Minister Gordon Brown, who straddled economic realism (ie global markets) and also ‘national values’ as embodied by institutions and services such as the NHS. But more of this later.

Meanwhile, in 1997 and for the next ten years, Labour talked of ‘old values in a new setting’…. but this was just rhetoric geared to the party faithful. When elected as party leader in 1994, Blair had still used the word socialism…but inserting a hyphen ie socialism (as in his address to the launch of the report of the Commission for Social Justice, chaired by Sir Gordon Borrie, of Monopolies and Mergers Commission fame, at the invitation of his predecessor John Smith.

At a post-modern stroke of a pen, he had reduced the ‘hard’ ideology of Labour to a woolly belief in the ‘social’ (Who could differ, apart from the Aunt Sally version of
Margaret Thatcher quoted out of context by her enemies as believing that there is ‘no such thing as society.’

Later, social democracy too fell by the wayside, to be replaced by the ‘triangulated’ concept of the Third Way. It was this concept which was initially applied to health policy – mechanistically and again derivatively, as a political strategy rather than a policy development. (This belief in ‘politics as policy’, with implementation looking after itself, to boot, would come back to haunt Blair and New Labour, in general and especially on the NHS.)

The NHS was different, however, from many other areas of the economy and even of social policy: as Blair himself had said in the foreword to his NHS Plan of 2000, the NHS’s creation in 1948 was ‘the greatest act of modernisation ever undertaken by a Labour government.’ Thus – on the NHS unlike anywhere else – New Labour traced its roots willingly to Old Labour, crediting the latter (for once) with ‘modernisation’ – the New Labour mantra. This may seem an arcane point, but it was to have practical import for the Blair tenure of the NHS: New Labour was characterised by breathless and persistent ‘modernisation’ and legislative and administrative hyper-activism.

Yet, in the case of the NHS, this was actually less needed. The ten years of Blair condemned the NHS to persistent ‘initiatives’ and at least four major re-organisations – which were circular rather than linear in their destination. It need not have been so. In his desire to be ‘business-like’, Blair confused legislative rhetoric with business strategy and disobeyed key business tenets, to boot (such as the need to have a limited number of stable priorities.)

A Distinctive ‘New Labour’ Route to Modernisation?

The ‘third way’ can be debated as a concept in general political economy. Its application to health by government spin-doctors was however mechanistic and short-lived. A caricature of the NHS from its foundation in 1948 up to the ‘Thatcher reforms’ which introduced an ‘internal market’ in 1991 was as ‘centralist command and control’. This was said by New Labour to have been the ‘first way’; with the Thatcher internal market as the ‘second way.’ The third way was, in 1997, to be neither centralism nor market: instead, local health ‘economies’ were to collaborate to make things work.

Of course the original ‘third way’ had been an alternative to both capitalism and communism, and had embraced political phenomena ranging from Tito’s Yugoslavia to the non-aligned movement more generally; and within countries such as the UK the ‘national socialism’ of movements such as Sir Oswald Moseley’s New Party, as well as more benign versions of social democracy. The Blairite third way was arguably mid-way between social democracy and Thatcherism – and therefore perhaps best characterised as the fourth or fifth way!

Whatever, the rhetorical trick involved in creating the third way for the NHS belied the reality of central control in the NHS. This had (despite the caricature of the first way)
been growing from an almost total absence on central control at the beginning (as opposed to mild command, without the mechanism for control as opposed to persuasion.) The absence of control lay in the fact that – despite tidy organisation charts showing the hierarchy from central to local in the NHS – the main source of power (at this time, at any rate), the medical profession, was independent of any such ‘top down’ managerial pretensions. On this reading the Thatcher reforms deepened central control, despite their anti-state rhetoric; and soon New Labour found the need for its own version of central control.

By obsessing about third ways and later revisiting the market ideology, the Labour government missed the real challenge, which was more prosaic – to build on managerial reforms which sought more effective joint working between doctors and managers. The Griffiths reforms of 1983 were a starting-point, but Labour de facto abolished these by replacing local general management with central administrative control (moreover, down ‘silos’ based on different Department of Health divisions and branches which did not ‘talk’ to each other – leading to incompatible initiatives and (for the NHS frontline) targets.

But to return to New Labour at the end of the millennium: was its approach distinctive? In one sense, yes. The alleged hierarchy-that-never-had-been of the ‘first way’ was at least in line with traditional public administration. The central control-by-targets which New Labour instigated in 1999-2000 was more like a version of the Sun King’s ‘l’état – c’est moi’, with the Health Secretary of the time seemingly saying to a bewildered and battered community of clinicians and managers, ‘l’NHS – c’est moi’! We might call this the New (Labour) Public Administration, rather than either traditional public administration (misleadingly classified as hierarchy by the New Labour spinmeisters) or the new public management (itself an umbrella phrase conjuring up an ethos rather than any precise set of practices.)

This betrayed a key characteristic of Blairite public administration – central whim (after central whim), accentuated by the struggle between Blair’s Premiership and then-Chancellor Gordon Brown’s Treasury – which, between them, piled up complex and often conflicting ‘performance management regimes’ for the NHS in England (based on the Treasury’s public service agreements, and more detailed performance assessment frameworks, on the one hand, and the Prime Minister’s ever-changing policy fads, on the other hand.)

Labour had inherited the structure of the previous Conservative government’s internal market and –despite much tinkering and persistent re-organisation, generating much heat at the time but little light in retrospect – never removed it. In essence this was the ‘purchaser/provider split’ between what were now to be called commissioners of health care and the agencies (such as hospitals) which actually provided it.

To this, New Labour added three distinct policy ‘regimes’, not all of which were new but which were emphasized at different times between 1997 and 2007. It added exhortations to collaborate (at first, via the NHS third way), from 1997-1999; then central control, the
heyday of which was from 1999 to 2002 (although de facto central control continued to 2006 and arguably to this day); and – trailed in 2002 yet only really implemented in 2006/7 – the ‘new market’ of patient choice buttressed allegedly by a new system of reimbursing healthcare providers.

Taken together, these stages have been presented by the ideologists and advisers of the Blair regime as a ‘cunning plan’ to move through central standards, to ‘pull up the NHS by the scruff of its neck’, towards the relaxation of central control and reliance on consumerism and the new market to ensure standards (and financial control.)

I have however offered a different explanation, based on the ‘garbage can’ approach to interpreting New Labour’s first ten years. This depicts each of these policy regimes as short-termist in origin and deriving most of its justification ex post. Moreover, and crucially, the four regimes – old and new markets; local collaboration; and central command and/or control – have co-existed, and still do, to an extent that causes confusion – certainly in implementation of policy and arguably in policy itself.

Old Tories and New Labour

There is a myth which has gradually gained the status of orthodoxy, concerning the health service reform which started with the Conservative NHS reforms (trailed in the White Paper, Working for Patients, in February 1989; enacted into legislation in the NHS and Community Care Act of 1990; and officially introduced on April 1st 1991) and which – eventually – continued in more virulent form under New Labour, trailed in 2002 by the deceptively brief and informal Department of Health paper, Implementing the NHS Reforms: Next Steps for Investment, Next Steps for Reform.

That myth, comprising inter-related and unproven assumptions, is that the NHS was failing; that there was a ‘consumerist wish’ for greater patient involvement; that this in turn necessitated market-like reforms to challenge ‘provider capture’; and that (in the Labour version) hospitals were the epicentre of elitist interests which were best challenged by emphasizing primary care as the ‘answer.’

There is no doubt, on either philosophical or empirical grounds, that the pre-reform NHS was not perfect. But we should not forget that orthodoxies come and go – sometimes for faddish reasons, and sometimes buttressed by deeper explanations from politics or (deeper still) from political economy. At the time, for example, the 1974 NHS reorganization was seen as the apotheosis of ‘managerialist modernization’, although it emphasized consensus management and cooperation between professions and managers rather than coercion of the former either by the latter or by the ‘invisible fist’ of the market.

The pre-1991 NHS had already been reorganized further in a managerialist direction – but without the market – by the Griffiths reforms following the publication of that eponymous report in October 1983.
In fact the Tory ‘market reforms’ of 1988/1990/1991 were occasioned by two influences. Firstly, there had been, from 1984 onwards in England, a technical debate about the best means by which health authorities (which in those days both planned services and provided them) could be reimbursed for patients who flowed across administrative boundaries. This created the option – one among many – of ‘cross-charging’, which created the technical prototype for the more ideologically-rooted ‘internal market.’

Secondly, the American adviser Alain Enthoven straddled the technical and ideological camps and was responsible for introducing the idea into mainstream politics – although this was only the immediate cause. The underlying cause was the government’s search for market reforms in the public sector. Even so, it was initially the fledgling Social Democratic Party, via former Health Minister David Owen, which took up Enthoven’s idea in early 1985 and only three-and-one-half years later the Conservative government, led by Mrs. Thatcher.

She had announced a ‘fundamental review’ of the NHS as a political ploy to ‘turn defence into attack’ when challenged about the low level of spending on the British NHS by international standards. By summer 1988, however, her review was labouring to produce a mouse. A big idea was needed, and Enthoven’s blueprint – or rather bare-bones sketch – was plucked from the political garbage can.

Nearly fifteen years later, the Blair government’s ‘new market’ reforms were no more born of a ‘consumerist wish’ than the Thatcher government’s had been. Similar to the attack on the Thatcher regime by the medical Royal Colleges, there was widespread professional dissatisfaction with the scattergun approach to health reform under Blair – high on announcement, low on coherence, negligible on implementation.

Blair’s response was however Reaganite as well as Thatcherite – ‘you ain’t seen nothin’ yet.’ The technical basis for his reforms was the one evidence-based bit of the package – that ‘price competition’ had failed in the previous internal market, and that Labour’s new market therefore ought to be based upon fixed prices (the ‘tariff’ of payment by results (PBR), a very English prospective reimbursement) with competition on the basis of quality. But this too had its problems, of which more later.

This is not to deny the ideological import of Blair’s public service reforms. And to understand that ideology one must remember that for the British Labour party, Blair was a ‘cuckoo in the nest’: he himself pointed to how he was an outsider, much more right-wing and accepting of the ‘Thatcherite settlement’ than even the conventional Right of his party.

The expression of this ideology – in terms of individualism and consumerism applied to public services – was not forced on Blair by public pressure, although the public rightly expected more of the NHS as citizens and as users than their grandparents in 1948. Instead, it was his way of proactively seeking to ‘dish the Tories’ as well as advancing his own agenda within the Labour party. Thatcher’s ‘consumerist’ reforms were more internally-oriented – as a way of putting pressure on managers and (it was hoped) doctors
to deliver more productive efficiency. Neither were the result of the broad sweep of social forces; of the ‘consumerist wish.’

More Myths

There is a perfectly respectable Marxist explanation of why the state invests in health services, even if it is against the orthodoxy of the age. Blair thought he had found a ‘third way’ to justify (limited) state activism alongside global capitalism. Karl Marx however had provided the rationale one hundred and thirty years before. ‘Surplus value’ to profit-takers can be increased by healthier workforces if the extra health is produced at cost less than its economic benefit. What better than an economical state health service to keep the costs of health workers down through its monopsonistic power. (And what sillier, therefore, than a government which seeks to break up that monopsony, in placing the ideological above the economic – or what Marx would call false consciousness.)

There are those who think that this view is disproved by the fact that state health services such as the British NHSs spend most on the (retired) elderly (Perri6). Not quite: if the labour force is to be reproduced, it cannot be diverted by familial and community care.

On this reading, doctors in state services are the new proletariat (Morone), albeit la crème de la crème of proletariats. They may still have political power, although less than before; they are now likely to be one of many plural interest rather than the insider elite. Again, this case is sometimes attacked by suggesting that provider interests are as dominant as ever. But it depends what you mean by provider interests (6’s mistake in review of me). In the USA, private healthcare capital is powerful. In the UK it is not – except to the extent that the (English) government foolishly brings it centre-stage, selling it the rope with which it can hang the public partners.

Of Macro and Micro Explanation

How do we reconcile the ‘determinism of political economy’ in explaining political economy with the micro explanations which suggest that alternatives are possible? Basically we do so by replacing ‘determinism’ with ‘constraint.’

New Labour was in tune with the prevailing political economy ie global capitalism in its turn-of-century neo-liberal variant. This meant the NHS had to be so much more efficient than alternatives that it could deliver more for affluent tax-payers and voters than they could buy for themselves privately….while also redistributing to the worse-off to some extent.

This in turn meant ‘reform’ to enable greater efficiency and effectiveness/quality. Yet the actual paths of (contradictory) reform undertaken reduced efficiency, although effectiveness in key service areas was increased and improved.
That is the sense in which the external environment (political economy) was a constraint, yet not determinant of the exact (pluralistic) political trajectory of reform – the latter being conditioned by aspects of political structure but (crucially in this case) also by political culture. The latter in turn was characterised by a kind or perverse ‘post modern’ initiative-itis.

The Legacy: Transformation or Tight Balance Sheet?

In terms of dry inputs and outputs (or outcomes), New Labour has spent a lot on the NHS and derived some benefit for this money. They have half-succeeded. Which means they have (so far) half-failed. More could have been done with the money (REFS.)

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