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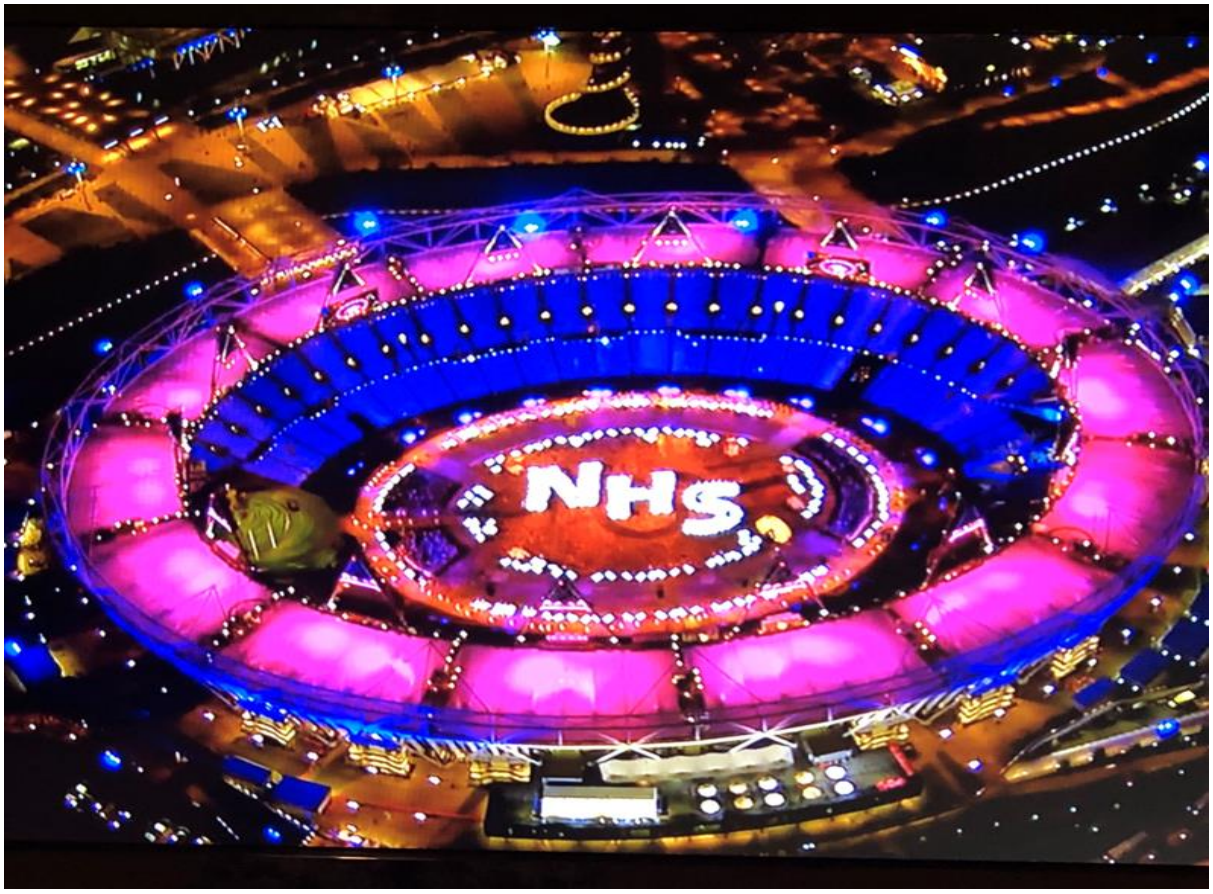


*A still image from the 2012 Olympics opening ceremony in London*

# *The neo-NHS: How neoliberalism has been transplanted into the heart of the British health service*

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## Summary

In 1948, Britain established a free health care system that was to be ran by the government, called the National Health Service (NHS). This led to the growth of a large public institution that was accessed by millions and became the country's largest employer. It is central to the British welfare state, which was implemented in the aftermath of the Second World War, as part of the 'Keynesian policy paradigm.' In the 1970s, a succession of economic and social crises delegitimised the Keynesian paradigm and led it to be replaced by 'neoliberalism.' This ideology heralded the era of the small state, free market economics and the ascendancy of the private sector. The neoliberal prognosis was that the welfare state was too expansive and needed to be reformed. This asked the question of whether the government could maintain something as large as the NHS. Over forty years later and the NHS is still in place, however, it has been subject to change. This thesis will study the NHS over this period to examine how neoliberal policy has led to the reform of the health service, whilst maintaining the principle of free health care provided by the government. I will try to find evidence of marketisation, privatisation and cuts, as they represent the core principles of neoliberal policy.

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# Introduction

The 20th century saw the rapid growth and deep embedding of the welfare state across the European continent. Governments recognised that they had a duty to provide some form of social provision for their citizens, to protect them from the risks associated with the world of international trade and finance (Kus 2006, 496). In the UK, successive administrations adhered to a post-war consensus of high public spending, rationalised by the economic doctrine of John Maynard Keynes (Keynesianism). Meanwhile, alternative ideas were disseminating in Europe and America following the meeting of like-minded thinkers at Mont Pèlerin, Switzerland, in the late 1940s (Plehwe 2009, 15). Masterminded by figures such as Friedrich von Hayek, a new ideology emerged – 'neoliberalism' – driven by a desire to diminish the role of the state and allow the orthodoxy of the market in the ordering of society (Hay 2004, 513-5).

Neoliberalism grew as a serious alternative to Keynesianism in the following decades, with post-war globalisation and the growth of international economic institutes aiding its spread (Fourcade-Gourinchas and Babb 2002, 535). In Britain, neoliberal thought was first espoused by conservatives think-tanks – independent institutions that give commentary and recommendations on societal issues – and brought into the mainstream by an emerging field of writers and columnists, who wrestled control of economic discourse away from elite academics. The expanding City of London had been freed from restrictions on the movement of capital by the Conservatives in 1971, resurging as an international marketplace that began to exert influence on the Bank of England and the Treasury (Fourcade-Gourinchas and Babb 2002, 552-3). This facilitated a 'paradigm shift' in the late 1970s, stimulated by a decade of crises that had rendered the Keynesian approach as obsolete (Hall 1993, 284-7). Margaret Thatcher was elected in 1979 with a commitment to transform the economy through Hayek's free-market ideas (Kus 2006, 507), and neoliberalism was firmly implanted into the heart of the British state.

What this neoliberal paradigm shift instigated was a crisis of the welfare state, which Basak Kus claims to 'make up perhaps the most contested and sensitive aspect of neoliberal transformation' (Kus 2006, 496). The electoral victory of 1979, which secured a mandate for their neoliberal agenda, was the Conservatives capitalising on the failures of a Labour government to maintain the Keynesian status-quo. Both Kus and Paul Pierson (Pierson 1996, 143-79) have found in their studies that despite neoliberal hegemony and an agenda to retrench,

the British welfare state, in particular the National Health Service (NHS), has remained surprisingly resilient. The NHS was created in 1948 by a Labour government to provide universal health care, free at the point of use, funded through general taxation and national insurance contributions. Since its inception, the NHS has been at the centre of British politics and subject to continuous plans and proposals aimed at improving efficiency and performance. The focus of this thesis is the extent to which the neoliberal paradigm – characterised by free markets, privatisation, freedom of choice and fiscal efficiency – has changed the NHS. I will attempt to show that welfare reform is politically complex, meaning this huge public institution, with an annual budget of around £150 billion and employer of 1.3 million people (The Kings Fund 2021), has largely stood resistant to change. Its main premise has remained, nevertheless, the health service has been affected by the neoliberal policy paradigm over the last 40 years. Therefore, my research question is: *How come the persistent drive for change inspired by neoliberal ideas has led to limited reform of the NHS?*

This raises a few sub-questions which will guide my analysis, notably:

*Why did successive governments attempt reform?*

*What were the main deterrents for attempting reform?*

*Who were the main actors driving reform?*

It is difficult to describe neoliberalism in a decontextualised statement, however, the core ideas of the new paradigm are: a small role for the state, a reliance on the private sector to provide services, and a free market supported by monetarist economic policies. These principles have been widely applied to economic and social problems of all shapes and sizes (Hay 2004, 513-4) and came to be adopted by all parties across the British political spectrum. The latter has been defined as the onset of a 'third-way' for social-democratic parties across Europe, most evident in the rebrand of the Labour party under the leadership of Tony Blair (Powell 2000, 42). The pivot of the Labour party to the political centre has been significant for the NHS, because as this thesis will demonstrate, it has meant that reform initiated a Tory administration was expanded instead of reversed when Labour came to power.

This neoliberal paradigm shift was all-encompassing as it established a new 'normal science' of policy, through which all future directives were to be perceived (Hay 2004, 504). This meant a new policy framework for the management of public services, New Public Management (NPM). The UK in the 1980s represents the extreme example of the application of NPM, which

was a wider trend tied to the rise of the neoliberalism. NPM had three core pillars: markets, management, and measurement. The public sector was scaled down and made more business-like, with services subjected to marketisation or the creation of 'quasi-markets.' This was supported by the implementation of a new professional managerial class tasked with delivering the main goals of the central government, that stripped power from trade unions and service professionals. With a focus on greater efficiency, output targets and external regulators were introduced to measure performance and encourage better quality (Ferlie 2017, 2-4). The NHS reform introduced in 1990 is a clear example of a stringent application of this new public sector approach.

The NHS is a social-democratic institution, in what Epsing-Anderson defines as a 'liberal' welfare state (Epsing-Anderson 1990, 144). Its existence creates a contradiction and has thus made it the fixation of neoliberal reform. Its universalist principles and funding through taxation juxtaposes the dominant idea of a limited state and freedom of choice. However, it has come to be endeared by many in the UK and was celebrated as part of Britain's 'identity' in a cultural history study of the NHS from Warwick University (Crane 2022). This was a part of the fanfare surrounding the 70th anniversary of its inception, which saw celebratory events attended by British royals at Welsh hospitals, the birthplace of its founding father, Nye Bevan (BBC News 2018). Reforming an institution with an interest group as broad and as entrenched as the NHS, whilst maintaining public support is a complex and lengthy procedure, which this thesis will explore.

## Theory

Central to this discussion is 'the politics of retrenchment,' the focus of Paul Pierson's *The New Politics of the Welfare State*, in which he seeks to explain the reasons behind the apparent lack of welfare reduction in European states. Pierson claims that when post-war economic growth stalled and continuous crises arose in the 1970s, attention was turned towards limiting social programmes, led by 'newly ascendant conservative politicians' across the European continent. The major reforms they began to advocate once in government had received external support by business (Pierson 1996, 145) and, as in Britain, had cultivated in financial institutions and think-tanks. The issue with these social policy reforms is that they often proposed 'tangible losses' on voters, and therefore required elected officials to pursue 'unpopular policies that must withstand the scrutiny of voters and well-entrenched interest groups' (Pierson 1996, 143). This is the opposite of welfare state expansion, which was the implementation of policies that

offered safety and support and were largely a process of claiming electoral credit. Pierson claims that governments try to lower the visibility of reform, as a result, retrenchment policies have been an 'exercise in blame avoidance.' Successful welfare state cutbacks usually only take place 'surreptitiously,' to avert potential negative repercussions. Alternatively, governments use moments of crisis to implement change on the back of greater public acceptance of cuts. Therefore, Pierson found that change has been incremental, despite the powerful political position that some administrations have enjoyed, such as under Thatcher (Pierson 1996, 143-79).

Pierson believes that institutionalist arguments about 'policy feedback' can be relevant to the politics of retrenchment. Pre-existing policy designs and their characteristics, which in the NHS case would be free universal health care, influence the so-called 'interest groups' that Pierson sees as barriers to successful welfare retrenchment (Pierson 1996, 154-5). You could propose, with over 1 million people visiting a GP every day (Kings Fund 2022), that the interest group of an institution as large as the NHS is the entire UK population, minus those already privately insured. This means that a significant proportion of electoral support could be lost as a result of repealing the NHS, hampering the extent to which the neoliberal agenda could be implemented in the UK. This is an effect of the health service being created in a different paradigm, when welfare expansion was the norm.

Pierson's argument has been critiqued or built upon by numerous academics and Peter Starke provides a useful overview of the literature on welfare retrenchment, which can be applied to this study of the NHS. State structures are important; therefore, institutional theories can help us to understand retrenchment. Theoretically, the capacity for retrenchment is greater in countries that have a high concentration of power, such as in the UK's Westminster system (Bonoli 2001, 245). Yet this also comes with the greatest level of accountability, which makes a blame avoidance approach more difficult (Starke 2006, 109). In Britain, health policy generates great publicity and scrutiny, which heightens the political sensitivity of the NHS. Throughout the period covered in this thesis, it will be shown that NHS was at the forefront of political discourse and featured heavily in the manifestos of the two parties. Despite political messaging repeatedly stressing support for the institution, I will demonstrate that there was private consideration of wholesale reform to the British health care system.

In studying the impact on public policy, Peter Hall sees the establishment of a new paradigm as the creation of a 'framework of ideas and standards that specifies not only the goals of policy

and the kind of instruments that can be used to attain them, but also the very nature of the problems they are meant to be addressing' (Hall 1993, 279). This is reflected in the application of quasi-markets and the competition element into the NHS, to improve the financial efficiency of the service. Hall later explained how policy development then becomes a process of 'social learning' (Hall 2004, 278-9), in which the work of policy makers is confined to the existing framework. This goes someway in explaining Labour's adoption of some of the reform ideas that were initiated by Tory policy makers, such as the internal market, were they chose to tweak the system rather than replace it. The neoliberal line of thought is that public spending, thus the role of the state, should be limited. The contracting out of public provision to the private sector is a central component of the neoliberal policy outlook adopted by British policymakers. It is a commonly held belief that the public sector is inefficient because of the lack of profit incentives and property rights. It is believed that only the price mechanism, introduced by contracting (Pollock and Price 2011, 296) and the introduction of markets within the public sector (Hay 2004, 514) can ensure cost efficiency. This will be important in categorising each reform as evidence of the adherence to this belief by British policy makers.

## Method

I intend to answer my question through a diachronic analysis of the NHS over a broad period of fifty years. This paper is a study of the recent history of the NHS, therefore, I will employ a causal narrative to show how the reforms came to fruition, interwoven with a historical narrative of the Conservative's and then Labour's time in government. This means explaining how and when power changed hands, between the parties and their leaders. I have chosen to begin in the 1970s as this was when the first structural reform of the NHS occurred, and the events of this decade were the catalyst for the paradigm shift which is central to this thesis. The study of reform will then be categorised by the political party that implemented it. This means first looking at the Conservatives between 1979-1997 and 2010-2012, and then Labour between 1997-2010. I will look for the same indicators in each act of reform. In accordance with neoliberal doctrine, these will be:

- reducing the responsibility of the government
- increased privatisation
- application of market principles (competition, freedom of choice, financial incentives)
- budgetary restraints

- cuts or reduction in services

The NHS is Britain's largest public institution, deeply entrenched in society. This means that there are a number of interest groups relevant to this thesis. As I focus on policy, politicians are the primary actors responsible for its implementation. The public is the second and largest interest group as they are users of the NHS, and politicians must seek their support for reforms through elections. Furthermore, public support for the NHS manifests itself in the form of activism. The impact of the relationship between the public and politicians on the capacity for the more radical reform ideas will be examined. The NHS is a huge employer, therefore, the position of representative bodies, such as trade unions, will feature selectively.

## Source selection

A variety of primary sources relating to the creation and implementation of health care policies will be analysed in this thesis. The majority of these will be White Papers, which are authoritative reports that set out and explain the governments intentions for policy. They precede the legislative acts that implement the changes, which will also be used. Written or spoken word from politicians, such as Prime Ministers and Health Ministers, will be analysed to see how they can be reconciled with action. The Conservatives and Labour will be the only parties compared and examined, as they each led government and orchestrated reform. The Liberal Democrats will be grouped with the Conservatives in my analysis of 2012, as they served as minority partners in a coalition. Other political documents, such as manifestos, cabinet papers and pamphlets will also feature. The drawback of my source selection is that the policy documents are authored by the government and are therefore very selective in the framing of policy. The government needs support from parliament, which comprises of members from across the political spectrum, for their proposals, which influences the explanation of the potential impact each policy could have.

## Secondary literature

Besides the literature that provides the theoretical framework to this thesis, there are several secondary sources that offer a narrative of events and explain policy. Dr Geoffrey Rivett has written an extensive book called the History of the NHS (2020) on behalf of the Nuffield Trust think-tank. This book is useful as it offers a description of the lifetime of the health service, that is supplemented by a medical professional's analysis of the ways in which it has changed.

Moreover, the book The New NHS: A Guide (2006) by Alison Talbot-Smith and Allyson Pollock, covers the same time period as this thesis. The book provides an in-depth explanation of the NHS structure and a breakdown of the impact that each policy change has had. Another book by Pollock is NHS Plc: The Privatisation of our Health Care (2004). Pollock is a staunch defender of the British health service, opposing the influx of private capital into the NHS and the expansion of the internal market that took place under the New Labour administration. These books will help me conceptualise the purpose and effect of neoliberal reform policies. Journal articles that focus specifically on health care and health care policy, such as International Journal of Health Services and the British Medical Journal, will also be used throughout this thesis.

As I have mentioned, the neoliberal paradigm shift coincided with the rise of think-tanks, which have come to be important and vocal bodies in British society. The Nuffield Trust and the Kings Fund are two examples of prominent health care think-tanks that regularly produce reports concerning government policy or NHS performance. These will aid my analysis by providing facts and figures that show the effects of neoliberal policies on the NHS, relating to for example, the growth in the usage of private providers to supply care. I will also regularly use news articles that either provide commentary or explain specific events relating to the reform of the NHS. The problem with my literature selection is that they are heavily susceptible to bias. Health care reform in Britain is a conscientious issue, with allegiances formed on political lines. As my focus is on retrenchment, commentary from health care professionals, like Pollock and Rivett, is often critical of the government. This can exacerbate the effects of the reforms in question, however, I will combat this with my own analysis of the primary source material.

## Structure

The thesis will be split into three chapters and a conclusion. The first chapter will briefly explore the main issues of the 1970s, and then focus on the circulation of radical reform ideas for the NHS in the 1980s. The fate of these ideas will be explained through an application of Pierson's retrenchment theory. The sub-question relating to this chapter is: *why did the government shy away from reform, despite the discussion of radical ideas in government?*

The second chapter will look at all the reforms implemented by the Conservative party in the 1990s and later in coalition with the Liberal Democrats in the 2010s. This will cover the introduction of an internal market to the NHS in 1990, which created a marketplace within the health service that required hospitals to act like businesses and sell their services to regional and local health authorities. I will then look at the health care policies of the coalition government for evidence of retrenchment. The sub-questions relating to this chapter are: *to what extent do these reforms embody the neoliberal principles of marketisation and privatisation?* And: *under what context were the Conservatives able to implement NHS reform?*

The third chapter will explore how the Labour government, led by Tony Blair, came to adopt and expand the neoliberal reforms initiated by the Tories. This meant an increasing reliance on the private sector in the NHS and an expansion of the internal market. This is shown by the influx of private capital through the Private Finance Initiative (PFI), which enabled external investors to raise the capital necessary for new NHS construction plans, in return for ownership of the assets. It highlights the dominance of the neoliberal policy paradigm, which Labour had embraced. The sub-question relating to this chapter will be: *how far does NHS reform under Labour represent the continuity of neoliberal policy?*

I will then conclude the thesis, reflecting on the timeframe as a whole and assessing the state of the NHS now. I will refer back to the literature on welfare state retrenchment and the core pillars of neoliberal policy, to see how far each have affected the NHS. Whilst neoliberalism didn't cause the Conservatives or Labour to end British citizens access to free health care, it considerably altered the way it was supplied, establishing a health service overseen by the state but with care often supplied by contracting with the private sector.

# Chapter 1: The NHS in the 1970s and 80s

## 1.1 On the waiting list

After twenty years of expansion, the National Health Service, like most things in the 1970s, ran into trouble in what was a turbulent decade for British society. Whilst in government, both the Conservatives and then Labour had to grapple with economic recession and fractured relations with trade unions. This put a strain on the health service, which experienced its smallest ever average annual budget growth of just 1.3%, between 1975 and 1980 (Nuffield Trust 2012). There was also a growing debate over the extent to which private practice should be allowed within the health service, with both serving as pretext to the direction of health care policy after Thatcher's election victory in 1979.

In 1974, the Conservative government created a new structure for the NHS, overseen by health minister and future key Thatcher advisor, Keith Joseph (Rivett 2020, chap.5). The service was restructured into a regional system, with 14 Regional Health Authorities (RHAs) created, coterminous with 90 Area Health Authorities (AHAs), which were in turn divided into 192 districts. The RHAs, working with the budgets sets for them by the then Department of Health and Social Security, were responsible for strategy, staffing, building and resource allocation to their subordinate AHAs (Department of Health 1973). Joseph wanted to strengthen the grip of management over resources and priorities, whilst limiting the freedom and influence of clinicians (Scott-Samuel 2014, 61), and these changes ensured that there was to be a strong level of centralised decision making, with a greater role for management, replacing the tripartite structure with a unitary one. The influential trade union, the British Medical Association (BMA) had stressed through in their weekly publication, the *British Medical Journal* (BMJ) that the most pressing issue for the NHS was the distribution of resources. This was heavily imbalanced towards the Southeast of England due to demands of the capital, leaving other areas of the country to suffer and the standard of care to fall. Therefore, the Resource Allocation Working Party (RAWP) was set-up to produce a new formula for the distribution of resources (Rivett 2020, chap.5) and was to remain relevant to future policy suggestions concerning the budget of the regional authorities.

The other issue was the growing discontent about the 'mixed economy' that was emerging in the NHS amongst staff and Union leaders. Allowing some private beds on NHS premises was an arrangement that had been in place since its inception, however, upon their return to government in late 1974, Labour were keen to phase this out. Around 30% of consultants were

spending their time caring for private patients at NHS facilities, meaning that they were not committed full-time to the NHS. The number of patients choosing private care was rising because of falling standards across the service and long wating times for patients (Rivett 2020, chap.5). It allowed those who could afford it to use the NHS and skip the queue, which flew in the face of the principle of universal health care distributed on medial priority alone and exacerbated staffing problems. Faced with opposition from the BMA, Labour failed to address the situation, as negotiations over full-time contracts with consultants stalled and the decrease in private beds led in turn to the increase in private hospitals (Rivett 2020, chap.5). Thus, private health care was growing in stature as the 1980s approached, when attention was to strongly turn towards alternatives, such as insurance schemes and the private sector in financing the British health service.

## 1.2 Consultation

The policy debate that took place during the Thatcher years was extensive; most proposals focussed on the ways in which the health service could be more financially efficient, yet some reform ideas threatened the very existence of the NHS. This chapter will examine the neoliberal characteristics of these ideas, as well as the difficulties the government had in implementing them.

The Conservative election victory of 1979 signalled the death of the Keynesian policy paradigm, which collapsed dramatically in the 'Winter of Discontent.' According to Colin Hay, the economic turmoil and fracturing of relations between the Labour government and the Unions, allowed neoliberalism to be 'predicated upon a public-choice inspired narration of an overextended state held to ransom' (Hay 2004, 509-514). Hay, in his explanation for the neoliberal paradigm shift explains the importance of crisis narration. The collapse of Keynesianism was an 'external' crisis with much publicity, experienced by the wider British public and not just policy makers. It established the context in which neoliberal ideas could be perceived as a serious alternative and solution to the problems the economy faced (Hay 2001, 200-2). Neoliberal ideas had been disseminating in the institutional mainstream through Think-Tanks and economic journalism (Fourcade-Gourinchas and Babb 2002, 552), meaning the stage was set for economic upheaval.

In a memorandum by the Central Policy Review staff (CPRS) presented to the cabinet in 1982, long-term policy options for the government concerning education, the health service, security

and defence were outlined. The pressing issue of the health service is stated as the need to make savings due to ever-growing demands driving up expenditure, which was a problem for the Thatcher government's cost cutting agenda. One option mentioned is the introduction of payments for overnight stays in hospital and the expansion of existing prescription charges (Central Policy Review 1982). Annex D states that, 'increasing the proportion of costs recovered through NHS charges clearly lessens the distinction between NHS and private treatment,' proposing that only certain groups could be entitled to free treatment. It is recognised that new and heavier charges would stimulate the growth of private insurance, going on to state that such an outcome would be a 'preparatory move before full privatisation' (Central Policy Review 1982). Annex E then outlines how a move to a private insurance scheme could work, citing how the American experience has resulted in cost savings. The inclusion of the radical idea of phasing out free health care and replacing it with private insurance as a 'long-term' option for the government, gives an indication of the level of intent of policy makers at the heart of Thatcher's government.

Nonetheless, there was disharmony in Thatcher's cabinet and the health secretary, Norman Fowler, was against the idea of replacing the NHS. Some of details of the report were then leaked to *the Economist* and public backlash and negative headlines led the PM to shelve the plans (Rivett 2020, chap.6), prompting her to state at the 1982 Conservative party conference that "The National Health Service is safe with us" (Margaret Thatcher Foundation 2019). However, as covered by *the Guardian* newspaper, treasury documents released by the UK National Archives in 2016 show that after the leak, Thatcher continued to push ahead with discussion of the long-term spending options of the CPRS. Private office papers of then chancellor of the exchequer, Geoffrey Howe, show that meetings with high profile members of the cabinet who were opposed, such as Fowler, were arranged only after a few 'tricky' parliamentary byelections in the winter of 1982 had taken place (Travis 2016). This affirms Pierson's theory that the fear of electoral backlash can halt potential reform. On the face of it, the PM was declaring her public support for the NHS to quell the fears of the electorate, whilst secretly pushing radical reform ideas inside Downing Street. This episode also raises the question as to whether the concentration of power effects outweigh the accountability effects (Pierson 1996, 154). The government had an extensive economic and social agenda, but only three years into her tenure, Thatcher kicked potentially unpopular NHS reform into the long grass, due to the damage it could cause despite having a strong position of power.

Pierson found that despite the UK experiencing a 'radical swing to the right' and Conservative hegemony, this strong concentration of power does not necessarily result in strong retrenchment (Pierson 1996, 161). The drawback of the Westminster system is that there is little or no way to deflect blame, as typically only one party is responsible for the implementation of policy. The NHS was the 'best issue' of the Labour party in the 1980s (Pierson 1996, 162), meaning that the concentration of political accountability in the UK forced a governmental retreat from NHS reform, given that the opposition was vocally supporting it. According to Pierson, there was a small decline in support for the welfare state preceding the Thatcher years, which then rebounded in the face of a concrete threat of cuts (Pierson 1996, 162). He acknowledges the NHS as an area where electoral backlash was particularly influential in Thatcher's pursual of reform resulting in a retreat. Whereas her government was successful in cutting social housing through the right-to-buy policy, and the wider privatisation of many other public industries (Pierson 1996, 161-3).

Despite this initial setback, the government were keen to find ways in which they could make the health service more efficient and improve problems of management, which had begun under Keith Joseph. In 1983, Thatcher sought to utilise the expertise of those in private industry by bringing in Roy Griffiths, director of supermarket chain Sainsburys, to lead a management review in cooperation with a director from both BT and United Biscuits (Rivett 2020, chap.6). This was the moment Thatcher set the NHS on a course for 'a shift from welfare state to market state' (Scott-Samuel et al 2014, 61). The Griffiths review was a symptom of the 'managerial revolution' as it applied the principles of New Public Management and was a precursor to the 1990s market-based reform (Scott-Samuel *et al* 2014, 62). The initial structural change it prompted was the introduction of seven special health authorities and the replacement of the AHAs with 192 district health authorities. The intention was to reverse Joseph's reforms by decentralising and allowing more decision making at a regional level (Rivett 2020, chap.6). Furthermore, the government introduced the outsourcing of laundry, cleaning and catering to the private sector; the first competitive tendering for NHS contracts (Scott-Samuel *et al* 2014, 62).

In 1985, a US economist specialising in health systems, Alain Enthoven, was commissioned by the Nuffield Trust to study the NHS and provide analysis from an American perspective. Having played a role in shaping US health policy, Enthoven's monograph, *Reflections on the Management of the National Health Service* (1985), was influential and was subject to discussion in both the pro-market think-tank the Centre for Policy Studies (CPS), and the BMJ

(Rivett 2020, chap.6). Enthoven painted a picture of an NHS 'caught in a gridlock of forces;' a stagnant institution paralysed by resistance to change from within. Enthoven put forward the inherently neoliberal idea of an 'internal market' to introduce the incentives to provide better quality of care and make cost savings (Enthoven 1985). He proposed that the NHS become a discerning purchaser of services from private providers, as to capitalise on the 'benefits of efficiency, innovation and competition' (Enthoven 1985, 22). His description of an internal market system involved the 192 districts resembling nationalised companies, each receiving a RAWP based per-capita revenue and buying and selling services from other districts and private providers (Enthoven 1985, 38-39).

The CPS itself had been considering how market forces could be incorporated into the health service and published a pamphlet titled, *Britain's biggest enterprise: ideas for radical reform of the NHS* (1988). The authors of the pamphlet were Oliver Letwin – former member of Thatcher's policy unit and future cabinet minister – and John Redwood – a new Tory MP and future secretary of state. The self-professed 'radical' reform ideas included restructuring the NHS as an independent trust that would purchase services from private providers or moving wholeheartedly to an insurance scheme (Letwin and Redwood 1988). In outlining what was 'wrong' with the NHS, the authors state their belief that the initial idea was born out of wartime spirit and that patients were not supposed to expect to 'be entitled to luxury treatment' (Letwin and Redwood 1988, 6). They believe that the issue of long-waiting times could never be eliminated in the NHS system which, due to the large patient group, uses priority of need as its basis for providing care. It is therefore no surprise that Letwin and Redwood turn to cooperation with the private sector, and the introduction of charges or 'health credits,' as a solution (Letwin and Redwood 1988, 15). Their national insurance scheme proposal varies from a flat premium to an income-based system, which either way posits patients as being financially responsible for their health care, rather than being covered by the state.

The purchasing of services from what was seen as a more efficient private sector is consistent in the proposals of Enthoven and the CPS. The incorporation of private providers is evidence of privatisation driving policy outlook. Moreover, the market mechanism was viewed as a necessary implementation for improving the service, to drive down prices and ensure that the government could get more for its money. The idea that the government should be wholly responsible for the provision of health care is an affront to the neoliberal concept of a small state. There was a clear discussion, both in and outside of government, of radical proposals that threatened the existence of the NHS.

Although Thatcher enjoyed a strong electoral position and faced a Labour party mired by splits and divisions (Bravati and Heffernan 2000, 166-69), when it came to the NHS the PM was clearly apprehensive. Any change along the lines seen in the CPRS document, such as the daily hospital charge, would be very difficult to present as anything other than a cutback. Pierson states that this is prevalent in the minds of policy makers when he writes about the 'potentially mobilised' (Pierson 1996, 151). Even in the absence of a strong political opposition, the fear that those impacted by retrenchment *could* punish the government in the polls, acts as a serious deterrent for those advocating reform. However, in the 80s activism in defence of the NHS did materialise in the face of what appeared to be a hostile government. Jennifer Crane outlined the history of NHS activism in an article that featured in the cultural history study on behalf of Warwick University. Activism was intertwined with left-wing politics, as the Labour led Greater London Council set up the London Health Emergency, an activist group that worked with professionals from within the service. The core message was that the NHS was under threat, which was aided by leaked documents that showed the government discouraging speaking out and that staff should choose words 'very carefully indeed' (Crane 2019, 11). She also writes that Thatcher became a mobilising symbol for activists who, with banners such as 'Maggie makes us sick' common at protests, made her the sinister face of what was perceived as creeping privatisation to which opposition was needed to 'Save our NHS' (Crane 2019, 7-8).

In 1987, Thatcher herself weighed in on the discourse by publicly admitting to being privately insured. Keen to express the element of choice, she said: "I exercise my right as a free citizen to spend my own money in my own way, so that I can go in on the day, at the time, with the doctor I choose and get out fast (Margaret Thatcher Foundation 2022)." In the following year, the PM announced that a review of the health service would be taking place, assigning a number of high-profile ministers, such as future PM John Major, Nigel Lawson and Kenneth Clarke to the task. The timing of this review, after a third successive election victory and second landslide in the previous year, is understandable (UK Parliament 1987). Furthermore, running alongside the discussion of reform was a growing media narrative that the NHS had serious shortcomings. This sentiment was shared amongst medical professionals and prompted the presidents of the three royal colleges – Physicians, Surgeons and Obstetricians and Gynaecologists – to issue a statement calling for a review of hospital services and the need for funding changes (Rivett, 2020, chap.7). As Colin Hay explained, public crisis narration enables opportunities for policy reform, (Hay 2001, 200-2) therefore, after nine years of power, Thatcher capitalised on this

perceived moment of crisis and her strong electoral position to publicly announce a review of the NHS that made reform an imminent possibility.

## 1.3 Conclusion

Despite the NHS surviving Thatcher's 80s without any major reforms taking place, her government had change in its sights and was even open to the radical overhaul of the free health care system. The outcome of the review was a White Paper titled *Working for Patients* (1989), which was to be the basis of the next wave of structural reform. There is no doubt that reform intent existed within government, and the ideological backdrop to future NHS reform can be found in the 80s. However, despite electoral dominance and Thatcher being in favour, she veered away from potentially toxic NHS retrenchment. Appeasing the electorate was a key deterrent for Thatcher's government. But, as the wider economic revolution instigated by Conservatives unfolded, ushering in the era of market orthodoxy and privatisation, (Reitan 2012, chap 2.17) it became more widely accepted that the NHS would be susceptible to the influx of private services and market-based reform. The decade had started with the very existence of the NHS under threat, with the PM favouring replacing it with insurance. The politics of retrenchment forced a retreat; it was much easier to convince the British people that competition and choice will drive down prices elsewhere, such as in privatising the energy sector or transport, but to immediately transplant neoliberal based policy reform on the health service was a different story. Particularly since the initial ideas presented appeared so radical in nature when compared with the pre-existing arrangement of universal free health care.

# Chapter 2: Marketing the internal organs

## 2.1 The 1990s

Having provided an overview of the discussion of potential NHS reform, both in and outside of government, my attention now turns towards what major changes did take place under Tory governments. I will attempt to show how these reforms were a realisation of some of the ideas that circulated in the 80s, and consistent with the neoliberal dogma of privatisation, marketisation and reducing public spending. The process of how and what change could be achieved was again complex. Political circumstances, government actors and economic crises were key to making reform happen.

Thatcher's NHS review ended up being the catalyst for a complete structural overhaul of the way in which health services in the UK were to operate. Ken Clarke was appointed Health Secretary in 1988 and provided candid insight of the internal political struggle behind the introduction of the internal market to a witness seminar held by the University of Liverpool in 2017. Clarke claimed that the NHS was in "crisis" because it was "completely unchanging," and subject to a tussle between those on the inside who demanded more funds and external pressure to constrain it (Department of Public Health and Policy 2018, 18). According to Clarke, "the case for reform screamed out," (Department of Public Health and Policy 2018, 18) but the direction was not agreed upon. In 1987, Thatcher's desired approach was to promote private health care, which had pre-empted her announcement of a review. He said, "they (the government) were going to an insurance-based system…essentially, tax relief for insurance," however, the Chancellor, Nigel Lawson, was not willing to sanction the idea, neither financially nor politically (Department of Public Health and Policy 2018, 22). Attention was swiftly turned to alternatives and as Clarke explains, the hegemonic belief within government of neoliberal principles – "we all believed in free market economics" – led the health department to use Enthoven's 1985 monograph as a basis (Department of Public Health and Policy 2018, 27).

The political sensitivity of the NHS means that elections influence the pace and extent of reform. This was evidenced in the sense of urgency that Clarke recalled to implement a policy on the back of a review: "we had got to get this damn thing in place well before the next election…What you cannot do is fight an election on a plan." (Department of Public Health and Policy 2018, 35). Announcing that there was going to be changes without providing the detail makes the government susceptible to politically charged accusations from the opposition. The Tories then pushed ahead with producing a *Working for Patients* without consulting

medical professionals – the BMA rejected the proposals – nor trialling the ideas, owing to the impetus of Clarke to force it through without delay (Department of Public Health and Policy 2018, 38 and Rivett 2020).

Clarke's Enthoven inspired reforms came to life in The *NHS and Community Care Act* (1990), which turned hospitals or groups of hospitals into semi-independent trusts, which were to act like businesses by selling their services to health authorities, which assumed the role of purchaser. Regions and districts were to receive funds, building upon the RAWP system, based on the size of its population weighted for age and morbidity (Department of Health 1990). Instead of receiving a block budget, hospitals or 'trusts' were expected to generate their own income and balance their books. Furthermore, the new trusts now had to effectively rent their premises by paying an annual charge, originally set at 6 percent, on the value of their land to the Treasury (Pollock and Talbot Smith 2006, 6-7). Furthermore, the act reformed primary care by introducing the possibility for general practitioners to become fundholders and thus purchase care for their local population. Individual or groups of practices with a population of over 5000 could opt to be given their own budget, from which they choose the type, quantity, and location of hospital care for their population. This reflected the belief that greater value could be found by bringing money closer to the patient, as GPs had more in-depth knowledge of the needs of their smaller patient populations, whilst also encouraging family doctors to be more financially responsible alongside their duty to care (Department of Health 1990).

This NHS reform reflected the core neoliberal policy goals of containing public expenditure, promoting responsibility, private ownership and entrepreneurship. This was a testament to the strength in belief amongst government policy makers that this was the way in which better functionality of the NHS could be achieved. Whilst other British industries had been directly subjected to the market, the function of this act was to 'simulate' the market within the NHS (Sorrell 1997, 71). The rationale behind the move was the concept of 'managed competition' (Pollock and Price 2011, 297), and the belief was held that introducing the purchaser/provider split, thus replicating the buyer/seller arrangement of an actual market, would improve efficiency across the service. With the new trusts competing for patients, prices would be driven down, cost cutting encouraged and in turn, the quality of care would improve (Sorrell 1997, 71). The trusts were subject to expenditure limits set by the Treasury and had a board of directors, with a CEO who submitted annual reports to Parliament. All this had to be closely monitored, therefore, the act also set-up independent regulators for both the functioning of the market and the quality of care (Pollock and Talbot-Smith 2006, 103-111).

In their analysis of the 1990 reforms, Iliffe and Munro characterise the internal market implemented by the Tories as a 'demand-led' model, with the market existing primarily between the providers and the GP fundholders. GPs theoretically know their patients better, however, they are only required to respond to individual demand and act as an agent for each patient's individual need and preference. They need not assess the health needs of a wider group as individuals could choose their GPs and change practice if they desired. Conversely, GPs can choose patients that are less likely to be a significant drain on resources. Offering patients this freedom of choice also created a market between patient and GPs, meaning an adverse competition element existed between fundholders and the demand for services fluctuated each year as a result (Iliffe and Munro 2000, 312). This reduces the effectiveness of the arrangement in providing better value for money, as some practices could function better than others, just like adversity in the success of businesses in a real market.

The Labour party, under the leadership of Neil Kinnock, seized the opportunity to attack the government over the reform, stating that the 1992 election would decide the future of the NHS. Their manifesto read: 'We will halt the commercial market which is creating a two-tier health service…the Conservatives would continue to commercialise and privatise the NHS until it is run as just another business' (Labour manifesto 1992). This stoked the fear that the Tories' reform had duplicitous intentions and directly states their opposition to the NPM approach of managing public services. Perhaps Labour's critique was not completely unfounded. The NHS internal market opened new avenues for the influx of private capital into the health service. The scale of private care that was operating on NHS premises increased as hospital trusts established private units to attract patients to generate revenue. On the flip side, some GP fundholders referred NHS patients to private hospitals (Rivett 2020, chap.7).

The Conservatives were able to pull of an electoral shock that upset the pollsters, as Major led them to a fourth consecutive victory, albeit a narrow one (BBC News 2005). This can be taken as evidence that structural reform of the NHS – the effects of which were not immediately clear – was politically palpable. It validates Ken Clarke's assertion that it was necessary to put concrete change in place rather than only discussing reforms, which had earlier harmed Thatcher's favoured private insurance plan. The election victory accelerated the pace of change, and it soon became clear that all hospitals were to become trusts. However, with resources already stretched thin, the changes led to forced mergers and the reduction of services, with 245 hospitals closed by 1994 (Pollock and Talbot-Smith 2006, 6). Opposition to GP fundholding waned and by 1995, 40% of the population was covered by GPs that had joined

the voluntary scheme. (BMJ 1997, 311). The Tories were able to shield cutbacks to the service, under the guise of making it more financially efficient whilst avoiding electoral backlash.

In an attempt to make the NHS more financially efficient, the Tories had moulded the structure of the service into a competitive marketplace, whilst opening the door further for private investors. This fundamentally altered the ethos of the health service, however, it did not sufficiently address the issues that it faced. The neoliberal commitment to limiting public spending had crippled the NHS by the time they left office; health care spending as a percentage of GDP had risen by a mere 0.7% in the 18 years that they were in power (Nuffield Trust 2020). The budgetary limits and the pressures of efficiency were increasingly leading to the rationing of care and services being cut. An ageing population and economic inflation had exacerbated the problems, creating a chronic underfunding issue (Rivett 2020, chap.7).

The overall picture of this period of Tory reform is one of 'the progressive privatisation of all elements of health care, alongside a reduction in the state's role' (Iliffe and Munro 2000, 323). The prominence of private finance steadily increased, beginning with the competitive tendering of menial services under Thatcher. Rivett writes that 'the boundary between the NHS and private medicine was becoming blurred' (Rivett 2020, chap.7) and the income of trusts from private patients rose by 63% in the first three years of the internal market (Iliffe and Munro 2000, 323). The decentralisation reforms reduced the national accountability of the government in Parliament for the performance of the NHS, a precursor to next wave of Tory reform in 2012. The GP fundholding scheme, for example, whilst reducing the costs of providing care, meant that some GPs who didn't spend all their budget on care built up surpluses, which they spent on improving facilities that they owned (Iliffe and Munro 2000, 322). The reduction of political accountability and relinquishing control over local services is consistent with the neoliberal principles that dominated the policy outlook. The Tories had set about restructuring the NHS in line with a neoliberal agenda of diminishing the role of the state and increasing the opportunities for private capital and choice.

## 2.2 Restricting the blood flow

The Tories returned to power by winning 307 seats in the 2010 general election, which produced a hung parliament result. This meant that they had to govern in a coalition with the Liberal Democrats who won 57 seats (BBC News 2010), as the Labour party paid the price for the fallout of the 2008 global financial crash. The neoliberal diagnosis of the economic situation once again stated that the maintenance of a large welfare state inhibited economic growth. In concordance with the neoliberal view on the role of the state, the coalition government

embarked on a programme of economic austerity. In policy terms, this means that the government imposes spending cuts, often accompanied by tax increases, in an effort to control public sector debt (Corporate Finance Institute 2019). Pierson outlined that one of the ways in which retrenchment can successfully occur is in the aftermath of a crisis. In a 2011 article on the potential impact of the financial crash on the welfare state, Vis, van Kersbergen and Hylands conclude that all theoretical perspectives 'converge' around the idea that the crash was an opportunity for 'radical reform' (Vis, van Kersbergen and Hylands 2011, 339).

The Tories made the economy the focal point of their election campaign, and their success as the largest party indicated the shift in public opinion towards an acceptance of the need for welfare state reform. Opinion polls from 2010 showed that 70% of British respondents agreed that proposed spending cuts called for the welfare state to be 're-examined.' The poll didn't detail what this re-examination would look like, but crucially it found that only 8% of respondents felt that the biggest cuts should come to health care (Vis, van Kersbergen and Hylands 2011, 343). Public opinion was still a barrier for retrenchment and the Tories – alert to the strength in sentiment and keen to get elected – ran with billboards featuring leader David Cameron's face and the words: 'We can't go on like this. I'll cut the deficit, not the NHS' (the Guardian 2010). This was the most vocal the Conservatives had been on the need for cuts, yet they were clearly keen to assuage fears that this would have consequences for the NHS.

Cameron's government and his health secretary, Andrew Lansley, reverted to the neoliberal handbook as the blueprint for NHS reform. The White Paper *Equity and Excellence: Liberating the NHS* (2010) detailed how the service was to make £20 billion in efficiency savings in four years by completely decentralising: 'we will radically delayer and simplify the number of NHS bodies and radically reduce the Department of Health's own NHS functions' (Department of Health 2010, 5). The latter meant the removal of the historic responsibility of the Health Secretary to provide or secure services for the population (Pollock and Price 2011, 299). The power and responsibility of commissioning care was devolved to local consortia of GPs 'freed from government control' and regulated by an independent NHS Commissioning Board (Department of Health 2010, 27-28), with no government bailouts (Department of Health 2010, 46). The freedom to choose any GP, any provider or any treatment was re-asserted as part of 'putting patients at the heart' of the service (Department of Health 2010, 3). Section 75 of the subsequent *Health and Social Care Act 2012*, states in its provisions for the procurement of contracts that 'competitive tendering' must be adhered to. While national standards were still in place, the government was 'liberating' the NHS by embracing the market framework and

relinquishing central control in the belief that the service was better left alone to function as a compendium of autonomous local bodies. There was, as with previous periods of NHS reform, much furore about the 2012 legislation with most trade unions stating their opposition (Thelwell 2012).

Despite Cameron's election pledge, the NHS was not to be exempt from the effects of austerity which was rigorously adopted by the coalition in response to the economic recession. The Nuffield Trust published a report *A Decade of Austerity* (2012) on the implications of the government's spending plans for the NHS. The 2010 Spending Review announced widespread cuts to the public sector, while the NHS was to receive annual increases of 0.1% in spending (Roberts, Marshall and Charlesworth 2012, 10). This was the duplicitous presentation of a cut as it was essentially a budget freeze on a service that had enjoyed average annual increases of 4% throughout its history. The Nuffield Trust report stated that efficiency savings outlined in the White Paper were 'unprecedented,' concluding that anything lower than the previous 4% yearly budget increases would necessitate a reduction in services and a potential budget deficit of £54 billion by 2022 (Roberts, Marshall and Charlesworth 2012, 6-11).

The rationale behind the 2012 reform is consistent with that of previous policies stipulating that a competitive market could improve the service by encouraging it to be more resourceful. However, this was applied alongside the most austere control of the NHS budget during the time of this thesis. In line with Pierson's theory, this was a 'duplicitous' way in which the Tories were able to facilitate a minor retrenchment of the service. The reality was that the NHS was cut during this period, as part of the government's welfare reform programme that was described by the Human Rights Watch as 'draconian' (Human Rights Watch 2019). The NHS has been forced to reduce capacity over the last decade, in cutting the number of beds and nurses in all areas of the country (Campbell 2019) which is consistent with the predictions of the Nuffield Trust report. The dual burdens of inflation and population growth ensure that enforcing fiscal efficiency on the NHS and applying the market ethos, cannot solve the innate characteristic that a publicly funded health service needs sustained budget increases to meet demand. Neoliberalism creates an irreconcilable dynamic between restricting public finances, and demanding improvement of the health service. The application of the two onto the NHS during Tory governance has resulted in the service having to make cutbacks to survive. This paper will now turn to analysing the approach of the Labour party to NHS reform.

# Chapter 3: A lease of life

The NHS functioned in a different way to the last time the Labour party had control of the service in 1979. The structure had changed due to the NPM approach in managing public services, that was born out of the neoliberal paradigm. However, the new administration was not like the Labour of old; Blair's party were firmly entrenched in the new paradigm. Yet they still had a different perspective on the size of the state than the Tories and were willing to spend more money on the service. The result was *some* continuity of policy, which this chapter will now demonstrate.

## 3.1 Policies

The rebranded 'New Labour' returned to government with an emphatic victory in 1997, immediately putting them in a powerful position with a 179-seat majority (BBC News, 1997). The party pledged to 'save and modernise the NHS' and they reiterated in their manifesto a commitment to end the internal market reform and replace the GP fundholding system. They claimed that the Tories had 'imposed on the NHS a complex internal market…The result is an NHS strangled by costly red tape' (The Labour Party 1997). This is important as I will uphold it to the actual outcomes of Labour's time in power. Throughout the 80s, Labour repeatedly tried to portray themselves as defenders of the NHS (Pierson 1996, Rivett 2020 and Crane 2019). The manifesto was most likely rhetoric that pandered to the electorate and its traditional support base of the trade unions. It also appealed to medical professionals by pointing to long waiting times, highlighted the reduction in nursing staff, and targeted savings in 'bureaucracy' costs to solve this (The Labour Party 1997). The opposition of activists and from the BMA to the internal market reforms likely dictated Labour's position going into the election.

It is relevant to explain what the neoliberal paradigm shift meant for political parties like Labour. Across Europe and America, social democratic parties came to adopt what has commonly been referred to as the 'third way.' The hegemony of the market and necessary role of the private sector was recognised and came to be incorporated into their policies. For Labour, their adherence to neoliberal doctrine was demonstrated when it ditched the party's historic commitment to the nationalisation of public services, the symbolic 'Clause IV' (Brivati and Hefernan 2000, 146). This reflected Blair's desire to modernise the party and he now instead spoke of a 'public/private partnership' in society (The Labour Party1997). This meant that services would be provided by the state but may be financed by the private sector, with a stress on effective collaboration. Welfare reform was to be central to Blair in legitimising his

governments credentials and the party claimed to be the 'the party of welfare reform' upon its election to government (Powell 2000, 39).

This claim related more specifically to the party's approach to reforming the welfare system around incentives to work and earning benefits (Barrientos and Powell 2004, 19). This signalled the 'Anglo-American consensus,' owing to the adoption of the same strategy by Bill Clinton and the Democrats in America. Yet this embrace of a welfare reform agenda, traditionally of the right-wing, can also be referred to as a 'neoliberal consensus' (Driver 2004, 35). Upon its ascension to government, Labour accepted the new paradigm and its analysis of problems the welfare state faced. The NHS, while maintaining an adherence to its core principles, was an institution that needed to operate better and should be subjected to the greater involvement of a more efficient private sector. The NHS was not going to be cut under Labour, however, it was to be subjected to 'an unparalleled level of change, organisational, clinical and financial' (Rivett 2020, chap.8).

The new government acted fast in setting out a plan for the NHS and produced a White Paper – *The New NHS – Modern, Dependable* (1997) – within six months of the election. Blair stated in the foreword that people had put their faith in him because 'the NHS was failing them' and it needed to 'modernise to meet the demands of today's public' (HMG 1997, 1). In listing the challenges the service faced, the paper rejects alternative methods of health care provision, reaffirming Labour's commitment to universal free care, in conjunction with the support of the public (HMG 1997, 8). Labour was keen to portray itself as a defender of the service, given that they were about to embrace the bulk of the recent Conservative reforms that they had spent the last seven years attacking. The new Health Secretary, Frank Dobson, stated in parliament that the White Paper "abolishes the wasteful and bureaucratic competitive internal market introduced by the Tories" (UK Parliament 1997). The reality was that the internal market was to be tweaked, not scrapped.

Labour differs from the Conservatives in that they rejected the idea of competition, and instead encouraged partnership and co-operation through mergers between trusts and regional health authorities (Powell 2000, 51), replacing the contracting element. This involved reconfiguring the internal market to make it 'needs-led,' in which the most important purchaser is the health authority that is acting on behalf of a geographic population. The health needs of this population are assessed by the respective authorities, so that they can purchase adequate services. This means that deeper information and evidence needed to be gathered on the effectiveness of the

services purchased, in order to maximise gain from a fixed budget. Theoretically, authorities could get better value for money by identifying the needs of a large population group, rather than GPs assessing the needs of individuals. The idea was that this would encourage greater quality and equity in access to care (Iliffe and Munro 2000, 312). This was reinforced on a local level, with fundholding abolished and replaced with Primary Care Groups (PCGs). PCGs were wider organisations of primary care professionals, like nurses and local community representatives, that were tasked with providing local health services and commissioning hospital care for their populations (HMG 1997, 21).

The government's strong majority and the minor nature of the proposals ensured that they became law in the *NHS Act* (1998). The reform represented Labour's 'third way' ethos as it maintained some of the market functions, such as the purchaser/provider split. But this was done without the same belief as the Conservatives that competition alone would sufficiently achieve the same desired result of greater cost efficiency. They further swayed from neoliberal ideology by reducing the freedom of choice element for patients and reasserting tight central control over the NHS. The latter meant stricter regulation was introduced that required health authorities and local governments to agree on a health improvement programme, setting out common public health goals to be attained. Furthermore, the National Institute for Clinical Excellence was established to monitor the introduction of new drugs and technologies, ensuring level standards across the country and prioritising effectiveness (Department of Health 1998). Perhaps most importantly, Labour was to demonstrate its commitment to the NHS by giving it the financial support it had been desperately craving.

The Tories commitment to restraining public spending between 1979-1997, meant that by the time Labour came to office UK spending on health care was well below the European average, despite the prevalence of insurance schemes in most countries. Labour had promised to abide by Tory spending plans in its first two years in office, which further exacerbated the issues the NHS was facing. A winter crisis in 1999 garnering negative headlines (Rivett 2020, chap.8), led Blair to announce on the BBC talk-show, *Breakfast with Frost*, that NHS spending was to be brought in line with the European average by 2005. The announcement of January 2000 has been dubbed 'the most expensive breakfast in history' and was done without prior knowledge of neither the Treasury nor the Department of Health (Timmins 2021, 11). The chancellor, Gordon Brown, subsequently included average spending increases of 6.1% for the next three years in his 2000 budget, and an independent review, the Wanless review (2002), was to identify the long-term spending needs of the health service. The government delivered on

Blair's promise; spending increased from 4.73% of GDP in 2000, to 7.59% in 2010, thanks to an average increase of 8.2% during Blair's second term (Rivett 2020, chap,8). Labour oversaw the biggest and most sustained spending increases in the history of the NHS, a stark contrast to the previous Conservative years, and was a clear break from the neoliberal approach of restrained public spending.

Despite this public cash injection, Labour was to continue the neoliberal reliance on the private sector. The Private Finance Initiative (PFI) was first introduced by Major in 1992 as an alternative means to mobilise capital for public investments. A consortium of banks, construction companies and management firms could raise the capital to bid for a contract to build, design and maintain NHS premises. In return, NHS trusts pay an annual charge over the duration of a contract (Pollock and Talbot-Smith 2006, 91). It came to be prominently used in the NHS as the government could keep the large investments that were needed for decaying facilities off the public balance sheet (Shaoul, Stafford and Stapleton 2011, 4), the reflection of a more neoliberal concern for the management of finances. Under the Labour government, PFI schemes accounted for 90% of all hospital building (Pollock and Talbot-Smith 2006, 7).

The typical PFI contract length was between 25-30 years and left NHS trusts tied to expensive annual payments to private investors, eating into their revenue over a prolonged period. The new business-like models that had been established for hospital trusts meant that this was a suitable way to acquire capital, whilst also enabling the government to appease the private sector. This was seen as an acceptable bargain for tying NHS trusts to crippling repayments. For example, the PFI contract for Barts hospital trust in London will cost five times more than the initial outlay of £1.2 billion by the end of the contract (Campbell 2019). The belief that the private sector could provide greater cost efficiency and innovation in design had seeped into Labour's outlook. Previously, hospital building had been funded by central government, but Labour's stance highlights the extent to which the neoliberal paradigm had pierced party policy. Labour's use of PFI is symptomatic of the 'third way' and its 'pragmatism' in adopting the reliance on the private sector to bolster public services, (Shaw 2004, 66) which is a far cry from the party's historical fervent opposition to the private sector.

Over the course of the 2000s, Labour continued tinkering with the health service through several proposals such as, *The NHS Plan* (2000), *Delivering the NHS Plan* (2002) and *Our Health, Our Care, Our Say - Community Care* (2006). What is evident in these plans is that they gradually harked back to what the Conservatives initiated. Alan Milburn was the health

secretary pioneering most of these changes, a man who later advised the Tory/Lib Dem coalition and has moved into private healthcare since standing down as an MP in 2010 (Davies 2015). One notable structural change was that PCGs became independent trusts (PCTs) and the numbers halved, with the power to arrange care devolved to them from the regional health authorities, which also reduced in numbers. This perpetuated the belief that NHS bodies were in a better position when operating under a duty to balance the books. Furthermore, PCTs were free to choose from any suitable provider, reopening the window for private health 'we will continue to use private providers where they can genuinely supplement the capacity of the NHS – and provide value for money' (Department of Health 2002, 4).

Despite introducing tighter centralised control with the intention of ensuring a consistent level of quality, the government decided to embrace the private sector's offer of extra capacity. The Nuffield Trust and the Institute for Fiscal Studies published a research report into the relationship between public and private in the provision of health care under Labour. The report's findings indicate that NHS spending on private providers 'increased markedly from 2006 onward, reflecting explicit policy decisions' (Arora, Charlesworth, Kelly and Stoye 2013, 5). It appears that the liberation of PCTs to choose any provider led to a significant increase in role for the private sector. PCTs spent three quarters of their budget in purchasing care from secondary services, namely hospital trusts. From 2006 to 2011, the proportion of this spending on non-NHS providers rose by 76% (Arora, Charlesworth, Kelly and Stoye 2013, 12). The report takes the example of hip and knee replacements to demonstrate how this increased role for private sector materialises. Examining the same period, the report states that the total number of publicly funded (NHS) hip and knee replacements rose by 30%, while the number of privately funded replacements fell by a similar percentage. Meanwhile, the overall number of hip and knee replacements in the UK remained consistent. Therefore, private health was receiving more of its income from the public purse (Arora, Charlesworth, Kelly and Stoye 2013, 24-27). What we can conclude from this is that the government's policy of relying on the private sector to increase NHS capacity produced direct results, changing the composition of health care provision.

## 3.2 Conclusion

The Labour years paint a mixed picture, with some form of reconciliation between neoliberal policy and the public provision of care. Labour was committed to the free health care principle of the NHS and maintained a large public sector, but one 'increasingly permeated by market arrangements and a more commercial ethos' (Shaw 2004, 77). The government pumped more

money into the NHS than previously to facilitate this strategy, which differs from the Conservative's more neoliberal approach of restricting the budget. In terms of outcomes for the NHS, this was perhaps a best of both worlds approach as the spending increases resulted in record levels of patient satisfaction by the time Labour left office in 2010 (Wellings et al 2020, 9). Despite being elected with a manifesto pledge to end the internal market, this didn't happen when in power. There was instead continuity; a reliance on the private sector and maintenance of the market structure, which is evidence of Labour's policy development being a process of 'social learning,' as explained by Hall. The party inherited an NHS shaped by NPM and slowly its own policy choices had similar directives, converting bodies into trusts and reinforcing the internal market. Moving with the neoliberal tide, Labour's third way meant that the NHS was to change from a services provider to a commissioning organisation (Pollock and Talbot-Smith 2006, 6).

# 4. Conclusion

This thesis has tried to demonstrate that despite the principle of universal free health care remaining untouched, the way in which the NHS functions has been altered considerably by neoliberal political ideology. The extent to which this paradigm came to transform government is evident in the initial ideas of Thatcher's policy makers and Tory politicians, who proposed dismantling the service and replacing it with a private insurance scheme. Such a move would ultimately suit the neoliberal outlook; the responsibility of the British state to provide health care would be erased. The trusted private sector would take up the mantle and a better quality, more efficient health service would emerge as the result of the establishment of a free and competitive market. However, to strip the population of a benefit – to which they have had a right to since the emergence of the country out of the horrors of the Second World War – is not easy. This paper has reaffirmed Pierson's theory, as despite the evolution of Britain's economy since the 1980s and the gradual degradation of the role of the state, this has not facilitated the end of the NHS.

We can refer back to Enthoven, the intellectual father of much of the NHS reform who, from his experience of the American system, acknowledged the complexity of the situation in Britain. In his 1985 monograph, he repeatedly highlighted the disincentives that politicians have for attempting notable change, such as the 'fear of political criticism' or being accused of 'tampering with the NHS' (Enthoven 1985, 10). This reflects how politics and governance are volatile and often unreconcilable concepts. Democracy demands a compromise of principles in exchange for legitimisation from the electorate. This has severely hampered the retrenchment agenda that neoliberalism proposed. Enthoven concluded that 'the nature of politics, medicine and the British culture make it overwhelmingly likely that whatever change does take place will be incremental and gradual' (Enthoven 1985, 12). His remarks ring true considering the internal market was still being tweaked over twenty years after its inception.

The special and complex status the NHS has in British society has proved to be a barrier to change. Its special stature can be perfectly encapsulated by the events surrounding the 2012 Olympics opening ceremony in London. Directed by the esteemed Danny Boyle, the ceremony featured 600 staff and 1200 volunteers displaying the NHS and Great Ormond Hospital logos, the latter being an international children's hospital in London. Boyle wanted the ceremony to demonstrate how the NHS is a key part of Britain and ensure that "everyone is aware of how important the NHS is to everybody in this country" (Crane 2018, 52). He later revealed that he had to resist government pressure – from the Tory/Lib Dem coalition – to reduce the size of

the NHS tribute, or even cut it all together (Nagesh 2016). This again reflects the neoliberal viewpoint of the service and is unsurprising considering that the coalition was facing backlash to further marketisation that year. Furthermore, in America, the country from which inspiration was drawn for the marketisation strategy, journalists were left 'puzzled' by the very prominent ode to the NHS (Harris 2012). This reflects an NHS that is loved by the masses, shunned by the government and misunderstood by outsiders.

So, what has the neoliberal paradigm meant for the fate of the NHS? The British welfare state has been reshaped and repealed by successive administrations since the 1980s, due to the neoliberal prognosis that it was in crisis. Marketisation and privatisation was implemented on a service at breaking point, however, four decades later and the situation is the same: "Winter after winter, the NHS has been warned it cannot go on the same as before" (Lintern 2019). Pollock (2011) notes that the competition authority of the UK has concluded that there is no 'clear evidence on the role of competition in driving performance' in health care (Office of Fair Trading 2010, 66). This raises questions about the adherence to neoliberal dogma, demonstrating the rigidity of the paradigm's policy framework, as explained by Hall. There has been much continuity in policy, with the main difference being Labour's spending commitments. Both parties did not expect the private sector to sit idly by, it was to be increasingly relied upon to help the NHS meet demand by expanding capacity and improving facilities. The evolution of the health service is that its principles have remained, but it has moved to 'a commercial system in which the NHS is reduced to the role of government payer' (Pollock and Price 2011, 302).

There are some limitations to this research, particularly relating to methodology. An expansion of this topic could pay more attention to the agency of individuals actors in driving NHS reform. The main architects of reform policies and advisors to the government could be identified and a network analysis conducted, to highlight who the main beneficiaries of increased privatisation have been. This could yield an analysis that posits British policy as health care capitalism. A more in-depth analysis of electoral results and opinion polls could supplement the findings of this research that the fear of voters is a legitimate deterrent for NHS reform. A government minister recently admitted that the Conservative's preparation for a health emergency, such as the coronavirus pandemic, was left 'wanting and inadequate' (Buchanan 2022). This is an indictment of government policy and provides an avenue for future research as to the extent to which neoliberalism created a weak and vulnerable health care system.

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