

## Worlds of difference

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In 1992, I published a paper in *The Lancet* called *Two paths for medical practice*.<sup>1</sup> This paper suggested that Health Minister Kenneth Clarke had, by imposing his Conservative government's new contract on general practitioners, set our profession on a backward path, from public service back towards the marketplace. The path forward was still there, but we had been pushed off it.

It was a shameful retreat from Nye Bevan's original trumpet call in the House of Commons in 1948, against British Medical Association (BMA) last-ditch resistance:

"I think it is a sad reflection that this great Act, to which every party has made its contribution, in which every section of the community is vitally interested, should have so stormy a birth. I should have thought, and we all hoped, that the possibilities contained in this Act would have excited the medical profession, that they would have realised that we are setting their feet on a new path entirely, that we ought to take pride in the fact that, despite our financial and economic anxieties, we are still able to do the most civilised thing in the world - put the welfare of the sick in front of every other consideration."<sup>2</sup>

His new path initiated a metamorphosis of medical care from trade in human desperation, toward science-led and evidence-based public service. It was only a first step, bound at best to take several generations to complete, but it was immediately popular with an overwhelming majority of voters. An equal majority of clinicians took slightly longer to be convinced that medical science could reach all who needed it better through tax-funded public service than through fee-paid trade.

From 1948 to 1989, no politician dared openly to challenge this gift economy that evidently worked, as judged by contemporary expert opinion.<sup>3</sup> A socialising UK National Health Service (NHS) then seemed irreversible, but nowadays every major UK political party endorses some sort of return to the marketplace. Voters are no longer offered the option of a public-service system operating as a gift economy, based on social solidarity and funded from progressive taxation. To understand this problem, we must look to its origins.

Adam Smith, founder of economics as an academic discipline, recognised greed as the necessary fuel for commodity production through exponentially rising productivity, which was made possible by capital investment in collective, organised production. However, as a professor of moral philosophy, he also anticipated Marx's theory of alienation.<sup>4</sup> This dangerous fuel needed constraint by a robust social framework composed of its opposite—public service, which is driven by social duty, not profit.

This frame was initially provided intellectually by religion, and materially by the Poor Law and *noblesse oblige*, which together formed a gift economy that

complemented the commodity economy. Women at home produced, reared, and socialised new workers. Craftsmen at work, and teachers in schools and universities, apprenticed and educated them. Priests, police, and prisons enforced their acceptance of priority for property rights over human needs. And a few people, at work, in universities, and in occasional crevices of the social machine, were allowed to create the new knowledge and ideas required for exponential expansion of its markets, without which capitalism could not survive. The economy of greed needed a parallel but subordinated economy of altruism, duty, and creativity.

Adam Smith warned that without investment in this parallel economy, capitalism would at best reduce men and women to machines, able to produce and consume, but no longer able to live the intelligent, creative lives of which all children are potentially capable. At worst, it would produce a demoralised population of wreckers.<sup>5</sup>

The most important part of this parallel gift economy was in the home. The results of sucking even this part into commodity production have been appalling, but this is not my subject. I want to look at the institutional gift economy, particularly institutional care of ill health. Until 1948, the institutional gift economy was still organised around the principle of less eligibility, which was originally adopted by Edwin Chadwick to make life in workhouses meaner, uglier, and more uncomfortable than the worst life outside<sup>6</sup>—a principle endorsed by Sydney and Beatrice Webb,<sup>7</sup> and by most other eminent social reformers of the early 1900s, when Lloyd George nationalised the local mutual aid societies developed by industrial communities out of their own material and intellectual resources, to create the foundations for liberal state welfare. There were reformers with warm hearts, like Dr Thomas John Barnardo, but generally the public service and charitable gift economy could afford neither generous feelings nor imagination. There seemed to be too many poor people for it to be safe to open the floodgates.

Better than any other leading contemporary politicians, Bevan knew those who lived outside these gates. Poor people value medical care higher than they did any other consumer good,<sup>8,9</sup> but he was confident that if it was transformed from a traded commodity into a human right, public demands would still relate to public needs. Despite many largely unsubstantiated assertions to the contrary, studies of specific problems confirmed that he was right.<sup>10,11</sup> Even nowadays, with most influences on opinion geared to consumerism, people go to doctors because of real fears or needs, not because they enjoy shopping. Until the NHS was thrust back into the marketplace, rising costs reflected expanding scope and effectiveness of medical science, not growing consumer

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avidity. Bevan's NHS transformed health care from a commodity sold by doctors as shopkeepers, to a service given by clinical teams as applied science.

The results of this change are even nowadays still in their infancy. The old gift economy provided social supports that were necessary for stable commodity production, but it was not and could not be profitable. Its gifts were never provided without some reminder that they originated not from those who work the economic machine, but from those who own and direct it. Its central concern was social control: any suggestion that free public services might impair private trade instantly incurred the wrath of commercial and supposed professional interests. State pensioners too sick, too old, or too poor to look after themselves fell into workhouse infirmaries, whose culture still operated well into the 1960s, long after their legal basis had gone.<sup>12</sup>

Like anyone else who lived in the south Wales valleys between the two World Wars, Bevan knew how the old public service economy actually worked. It crushed minds and bodies to save souls, and to preserve the social order within which business might flourish to create the wealth on which everyone had to depend. Into this stagnant substrate, Bevan introduced a vital seed—medical science released from dependence on fees, funded from progressive taxation. He made the development and application of medical science into a national enterprise, through what was—in effect if not in appearance—a shift of wealth and power from the few who owned the commodity production machine, to the many who worked it.

He conceded the demand of honorary physicians and surgeons (or Royal Colleges acting on their behalf) to carry their trading interests with them into NHS hospitals, and of general practitioners (or the BMA acting on their behalf) to stay unresourced in their primitive cottage industry. The English Royal Colleges and the BMA still gave priority to the interests of medical trade, over the interests of NHS full-time staff.<sup>13</sup> Bevan rightly anticipated that once the principal means of medical production were in public ownership, and services were freely available according to need, this seed would flourish in the fresh air and sunlight of international medical science. The professional opportunities opened by the transformation of health care from a petty, often irrational commodity in an always suspect trading relationship, to an effective, evidence-based gift economy in which both staff and patients could share in production of health gain, swept the ground from under the feet of the old leaders.

The marketplace to which UK political leaders and senior civil servants now compel the NHS in England to return<sup>14</sup> is profoundly different from the one that Bevan took over in 1948. In those days, medical trade was in the hands of established doctors, hospital consultants, or principals in general practice. Their claims to produce health gain were still too erratic, too

doubtful, and too closely bound to their personal judgments to provide much opportunity for profitable corporate investment. Those days are gone. Even doctors attracted to boutique medicine can no longer operate on the shopkeeping scale of the past. To make their millions they require serious capital, to fund staff and equipment resembling that which NHS hospitals still need to salvage their failures. The UK Government is seeking neither better shopkeepers, nor better public servants: it aims to hand the entire responsibility for planning and providing health care so far as possible to competing business.

As yet, the NHS has been turned back to the marketplace by stealth, and often by lying. The biggest lie, most essential to people trying to justify their so-called reforms, is that they transfer risks from taxpayers to private investors. Spurred by knowledge that if they fail they will be first to suffer the consequences, for-profit contractors are expected to work harder and more conscientiously than any public service to meet the requirements of their NHS contracts. Actual experience now provides many examples of health care for profit which have failed to deliver what they promised, even on the generous terms offered by governments determined to pursue this course irrespective of advice from the workplace. Private finance initiative (PFI) hospitals with a capital value totalling £8 billion will end by costing £53 billion, yet so far not one PFI value-for-money assessment has been released, because all the details of contracts and values are ruled commercially sensitive.<sup>15</sup> Runaway PFI disasters like the new Edinburgh Royal Infirmary,<sup>16</sup> the Norfolk and Norwich Hospital,<sup>17</sup> the NHS England information technology project *Connecting for Health*,<sup>18</sup> and ruinous dependence on outside business consultants, have all pointed to huge profits even where eventual salvage of essential public services has ended with taxpayers, as inevitably happens.

However, there are more fundamental reasons to anticipate global failure for marketised health care. First, its measured and rewarded product is always process, never health outcome. We might agree that this notion has been all too true throughout the history of clinical medicine, but as a public service we had at least the first promising shoots of health gain as our product, targeting human needs rather than consumer demand. The market tramples this aim underfoot, with a cocksure ignorance reinforced by virtually all lay media, until its failure becomes so obvious that this reality becomes the better story, with blame attributed to medical science or professional incompetence, never to the market process.

Second, by casting patients as consumers who are concerned only with their own gain, marketised health care fails to recognise the role of patients as responsible citizens, most of whom have welcomed social solidarity and collectively pooled risks ever since 1948.<sup>19</sup> For health care (as for any other commodity), the market promotes individual demand irrespective of collective needs.

Finally, it makes rational allocation of resources virtually impossible, marginalises public-health skills, corrupts public service by opening it to insider trading and promise of lucrative future corporate directorships, and impairs trust at every level between staff and patients.

Of course there is a way out. Though it operated outside the marketplace, the NHS never failed for that reason. Like other public services, everything possible had already been done to ensure failure by systematic underfunding, but this strategy was limited by what voters would tolerate. Even while the NHS tottered on the edge of bankruptcy, it was still more popular than any visible alternative. The last place anyone wanted to go was the health-care marketplace seen in USA, but that is our intended destination. Wales and Scotland are doing their best to get back on course, but with 84% of the UK population residing in England that will be difficult.

Even to return whence we came might seem better than where NHS England is heading now, but would solve nothing. In the 1980s, the portal of entry for business was the undemocratic nature of the NHS. Unless people we serve get a voice, they will eventually be hooked by choice. The old NHS was indeed a service for the people, not for shareholders, so it was a huge social advance; but it was neither by the people, nor of the people. When we renationalise the NHS, this must change: progress in this direction has become a precondition for the huge social movement that is essential before real reform can even begin. We need to rebuild the NHS from its foundations, in primary care<sup>20</sup> and in what is left of local hospitals. The only way that these changes can resist the fragmentation of care caused by market competition will be by restoration of personal continuity, and doing so far more comprehensively than we did in the old NHS, so that patients' life stories become central to information systems, rather than disjointed episodes of repair.<sup>21</sup>

The NHS in 1948 was the product of a social upheaval that was preceded by at least 20 years' development. Renationalisation of the NHS, and its rebirth as a public service on the basis of participative democracy, will require an even broader social base, with even higher expectations. Among politicians, only Bevan foresaw the Labour landslide of 1945 which led to the NHS, though his view was shared by most servicemen and women.<sup>22</sup>

From the birth of our public services in the late 19th century until 1979, the world of public service was separate from the world of business. Each had its own traditions, culture, career structures, and ambitions. Public service disdained participative democracy, but its ethics were real enough to eliminate most outright corruption, and it always contained seeds of a future society of cooperation rather than competition. Business

ethics were and are something else altogether—an oxymoron as self-contradictory as military intelligence. Only a massive swing of public opinion can retrieve public service from the marketplace, but when this change occurs, it will itself set public service onto a new course toward participative democracy, and the higher, more stable and sustainable society that we need to survive this terrifying century. Millions voted in what they thought was this direction in 1997. They were cheated, but enough of them know this, to make another and better 1945 not only possible, but as probable as Bevan foresaw in 1944.

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