



LOOKING BACK ON NEW LABOUR HEALTH POLICY

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THE CONTEXT

The UK National Health Service has been described as the closest that Britain has come to a national religion. Despite many reforms it is still largely free at the point of service and its personnel widely seen as dedicated to an ethic of public service. Its popularity is matched by its significance for British political parties. For the left the NHS is probably the most important public service institution upon which the whole of its reputation can depend. For the right, it has been, sometimes despite rhetoric to the contrary, an outmoded and self-serving machine too much a product of collectivist politics and antithetical a market economy. The NHS represents both vulnerability and opportunity and for this reason is highly politicised. Healthcare scandals are the stuff of national and local news alike. Add the (possibly waning) power of one of the few remaining traditional professions, medicine, and there is a

rich and complex environment for policy makers to act upon. Some say that those providing the service – doctors, nurses and very many others – benefit from this political prominence but if you ask them they are likely to crave less interference, fewer targets, less change.

The British NHS was set up in the years following World War II as a part of the new welfare state which aimed to slay the three giants of ignorance, poverty and ill-health. In fact, so optimistic were policy makers that the expectation was that the health service would largely be a temporary measure. The NHS had three founding principles that no government, however critical of collectivist welfare philosophy, has dared seriously question in fifty years of changing policy context. These are that it is free at the point of use, apart from a few exceptions; it is funded almost entirely out of general taxation with some contribution from national insurance payments, and an even smaller contribution of prescription payments (originally introduced to deter wastage); and that resources are distributed according to ever changing and sometimes complex allocation formulae that weight funding toward the geographical areas with the greatest health need.

New Labour was elected in 1997, after 18 years of Conservative management of the health service. For both governments, health policies reflected their approaches to the public sector as a whole. For Margaret Thatcher, the NHS represented a number of key challenges. One was to do with reducing the power of bodies that mediated between the state and the operation of a market economy. The traditional professions, notably in this case, medicine, exerted a degree of collective organisation and power that threatened the operation of both the state and a market. Another was the monopolistic character of the state-funded and state-provided health service that lacked any incentive, according to this thinking, to become either more

efficient or more responsive to 'customer' preferences. Her bold answer to this problem, with advice from US economist, Alain Enthoven, was the so-called internal market, where, in theory at least, the whole NHS was cleaved in two, to become commissioners of services or providers. Commissioners, and many General Practitioners (GPs) among them, were able to purchase services for their population wherever they wished. This principle, again in theory, was to incentivise hospitals and other providers to improve the quality and efficiency of their services.

By the end of the Conservative rule, the UK NHS was among the least well funded in Europe. In 1986 the health and social care budget amounted to 5.7% of the UK gross domestic product. In 2008/9, after a dozen years of Labour administration, the proportion of its allocation rose to 9.5%.

CHANGING POLICY

New Labour's arrival was marked by pledges to dismantle the internal market. Apart from its ideological unacceptability the internal market was seen to lead to some sharp inequalities in local service provision, giving rise to an example of the so-called postcode lottery. Health policy is always at least in part driven by high profile media concerns, and New Labour's promise to spend the savings from scrapping the internal market on reducing waiting lists and waiting times was no exception. The period was characterised by reports of patients left for hours or even days on trolleys waiting for hospital beds to become available. By December of their first year in office, New Labour had started to establish national standards of treatment and a programme of NHS modernisation. The founding of a Commission for Health Improvement (CHI), and National Institute of Clinical Excellence (NICE) in 1999 marks a key moment in New Labour Health policy. For the first time since the

conception of the NHS, a central body scientifically investigated the medical benefit and assessed the cost-effectiveness of different treatments and issued guidelines to the service, sometimes, not unpredictably, causing controversy. CHI, later subsumed into the Healthcare Commission, was the first body ever to assess the clinical performance of NHS providers and report the results publicly, also carrying out investigations where serious failures were apparent. Performance was now, at least beginning to be, open to central scrutiny and control in a way never before attempted in the UK NHS. Medical scandals such as the failure of children's heart surgery at the Bristol Royal Infirmary between 1984-1995 and the multiple murders of his patients by GP Harold Shipman during the 1990s created a context where control over medical activity was seen as an overdue priority. Performance indicators were set out and in September 2001 the Government published the first Performance Ratings for NHS Trusts providing acute hospital services. This was followed in subsequent years by ratings for other sectors of the service as well as the setting out and enforcement of various targets for performance, notably to do with waiting times.

The micro-management of NHS performance became one of the more controversial features of the Blair administration. With an increasing range of performance and quality data being collected by the Department of Health, and the abolition of intermediary NHS Regional Authorities, the way was open for 'career-limiting' telephone calls direct from the Secretary of State to Chief Executives of struggling NHS trusts, along with, according to a number of personal accounts, 'motivating' expletives. If the measurement of performance was conducted with scientific principles, the same cannot be said about the government's approach to performance management. During their time in office New Labour have achieved a level of command and control that their predecessors only dreamed of.

Labour also attempted to modernise the hearts and minds of NHS personnel. A number of, often short-lived, agencies such as the Modernisation Agency, formed in 2003 and replaced two years later by the NHS Institute for Improvement and Innovation were created aiming to promote innovative thinking, break entrenched ways of working and challenge traditional professional demarcations.

New Labour policy priorities can be seen in terms of two phases: from 2003-6 improving access and reducing waiting and from 2004-8 increasing patient choice and the range of healthcare providers. This is a second area where the Blair government outdid the Thatcher regime. The thinking was that if the independent or private sector could provide a service in a more timely, acceptable or efficient way then the NHS could purchase such services for the benefit of its patients. Legislation was passed enabling and in some cases requiring commissioners to contract with a range of service providers. In spite of these bold moves to encourage the activity of the private sector, strong differences remain between UK and US healthcare: in the US private healthcare providers and especially financiers such as insurance companies and Health Maintenance Organisations are a significant feature on the economic and political landscape and influence health policy, tending to resist, as we have recently seen with President Obama's reforms as well as the Clinton plan of 1993-4, efforts to rationalise the service as a whole.

However, in the last analysis, the Blair reforms and the major investment made by this government has produced mixed results. Although performance in the service has improved on many measures, and more information is in the public domain, the salaries of healthcare personnel have improved and waiting times have reduced, other problems either remain or have emerged. Health inequalities have not responded to various initiatives though the fact that the UK has seen three

Commissions on the topic in the last 40 years, and a number of initiatives shows its importance to policy makers of both major parties. Second, shocking failures of service or failures to respect patient dignity have come into view and it is hard not to connect these to some extent with a culture where NHS organisations and their leaders are placed under great pressure to meet certain targets, targets that sometimes look as if they are derived more from the desire to avoid media embarrassment than from coordinated system-wide priorities.

The UK NHS remains a major enigma: high degrees of personal dedication from its staff but poor morale, national campaigns for patient dignity but shameful system failures, powerful medical elites who feel disempowered by managers, (apparently) massive investment but insolvent hospitals, loved by the public but scandals are rarely out of the news. In the approach to the UK general election none of the major political parties dared speak of outright cuts to services, though the supposedly proliferating number of managers and the need for 'increased efficiency' were repeated. The NHS once again looks destined for financial attention—this time not of a good kind. Nevertheless, the careful phrases that politicians from all parties had been using gives an indication that the status of the service as quasi-religion for the British public is something that no one dares question.

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