

The London School of Economics and Political Science

A Giant Leap by Small Steps: The Conservative Party
and National Health Service reform

Tony Hockley

A thesis submitted to the Department of Social
Policy of the London School of Economics for the
degree of Doctor of Philosophy, London,

September 2012

Declaration

I certify that the thesis I have presented for examination for the PhD degree of the London School of Economics and Political Science is solely my own work other than where I have clearly indicated that it is the work of others (in which case the extent of any work carried out jointly by me and any other person is clearly identified in it).

The copyright of this thesis rests with the author. Quotation from it is permitted, provided that full acknowledgement is made. This thesis may not be reproduced without my prior written consent.

I warrant that this authorisation does not, to the best of my belief, infringe the rights of any third party.

I declare that my thesis consists of 75,000 words.

Abstract

This thesis investigates the factors involved in the processes of health policy change. It questions the validity of path dependency theory in the context of changes observed within the United Kingdom health system under the Conservatives between 1979 and 1997. The development of the National Health Service (NHS) 'internal market' reforms is considered together with five specific cases of change affecting public-private boundaries. The research combines literature research, including biographical and archival sources, with a selection of interviews with important actors from the health policy arena of the time. The cases are mapped using an adapted version of the three policy streams developed by Kingdon for the analysis of agenda-setting processes, as a structured basis for comparison.

The research finds little evidence of the self-reinforcing processes that are required to generate path dependency, or that a change of path can take place only at a critical juncture. It shows that small changes can produce substantive and enduring changes of path. It also identifies that the factors involved appear to go beyond Kingdon's three streams, and attaches importance to the potential for disloyalty to the status quo. Cultural or technical change, as well as policy change, can generate disloyalty amongst those who deliver services. The presence of the potential for disloyalty is, therefore, an important factor in the achievement of a change of path.

Taken together the changes between 1979 and 1997 show a notable consistency of purpose in pursuit of a dual agenda of consumerism and public spending control. Whilst analysis of individual cases of change can suggest an absence of strategy, each case plays a part within a remarkable consistent Conservative programme of change the roots of which predate the National Health Service.

Contents

ACKNOWLEDGEMENTS	6
1. INTRODUCTION	7
2. CONCEPTUAL FRAMEWORK	13
3. RESEARCH METHODOLOGY	39
4. THE CONSERVATIVES AND THE NHS 1944-74	55
5. THE NEW RIGHT 1974-1987	68
6. AN INTERNAL MARKET	87
7. AN INTRODUCTION TO THE CASE STUDIES	110
8. GENERAL OPHTHALMIC SERVICES	113
9. LONG-TERM CARE OF THE ELDERLY	127
10. PAYING FOR MEDICINES	146
11. TAX RELIEF ON PRIVATE MEDICAL INSURANCE (PMI)	159
12. ADULT DENTISTRY	174
13. ANALYSIS	190
14. CONCLUSIONS	216
REFERENCES	219
ANNEXE 1: CHRONOLOGY OF RELEVANT EVENTS 1979-97	233
ANNEXE 2 : HEALTH MINISTERS & SPECIAL ADVISERS 1979-97	236
ANNEXE 3 : TREASURY MINISTERS AND SPECIAL ADVISERS 1979-97	238
ANNEXE 4 – 1980 MEMO TO PRIME MINISTER ON CHARGES	239
ANNEXE 5 - PM 1979 NOTE TO TREASURY ON “PERKS”	241
ANNEXE 6 – EDWINA CURRIE DIARY AUGUST- NOVEMBER 1987	242

LIST OF TABLES

TABLE 1 MODES OF CHANGE	27
TABLE 2 SOURCES OF CHANGE	28
TABLE 4 NHS & INDEPENDENT BEDS 1983-96	133
TABLE 5 DENTAL REGISTRATIONS 1990-92.....	177
TABLE 6 FACTORS IN THE CASE STUDIES	207

Acknowledgements

This research would not have been possible without the support and encouragement of a large number of people over a long period of time. I am particularly grateful to my supervisor at the LSE, Professor Anne West, who has faced the significant challenge of keeping me on course to complete the work without sacrificing its quality. Professor Howard Glennerster has also been a wonderful source of inspiration and ideas, as well as encouragement, and I am very grateful indeed for his support and timely comments and advice. Neither Anne nor Howard share any blame for errors, which are all my own. Also at the LSE, Professor Elias Mossialos and my other colleagues at LSE Health have been welcoming throughout the time that I have been working on this thesis, and despite my occupation of much-coveted desk space amongst them. It has been a tremendous privilege to work alongside such a talented group of people. The interviews were of fundamental importance to this project and it could not have been completed without the time that my interviewees gave to me out of their very busy lives.

My fascination with the policy process was fed by the wonderful opportunities that I was given to participate in these processes in Westminster, and I will always be indebted to David Owen, Virginia Bottomley, Stephen Dorrell and Gerry Malone for allowing me to see policymaking from the inside. The most significant contribution has, however, come from my wife, Vanessa, without whose support I would not have even embarked upon this project and who pressed me to see it through to the finish.

1. Introduction

Background to the research

This study grew from the author's personal involvement in the policy process. Shortly before the 1987 General Election, whilst still a student of economics, I became involved in policymaking for the then Social Democratic Party (SDP), whilst it was in a formal alliance with the Liberal Party. When the SDP split following the election I remained with the independent SDP, under the leadership of Dr David Owen MP, and following my graduation in 1990 went to work for Owen in the House of Commons.

As Owen was both a former Labour Foreign Secretary, Minister of Health, and a doctor, his interests, and therefore my work, covered the range of policy. Major changes were underway. Internationally the Berlin Wall had fallen, the Soviet economy and society were changing, the first Gulf War was fought, and the European Community was working towards completion of the Single Market and taking the first steps towards monetary union through an Exchange Rate Mechanism (ERM). At home, Conservative divisions over the United Kingdom's relationship to the European Union and the unpopularity of the Community Charge, known as a "Poll Tax", led to John Major replacing Margaret Thatcher as Prime Minister, and then winning the 1992 General Election against most expectations.

Following the fall of Thatcher there appeared to be a centre-right political convergence on market-based social policies. Anticipating the inevitable demise of the SDP, I assisted Lord Kilmarnock in forming the Social Market Foundation (SMF) think tank in 1990, with financial backing from David Sainsbury¹. The SMF was created to continue the development of a distinctive social market approach to policy, which was gaining attention across the political spectrum. In February 1991, for example, I highlighted to Owen speeches by both the Conservative Party

¹ A Trustee of the SDP, Deputy Chairman of Sainsburys PLC. Funding came through the Gatsby Foundation charity. David Sainsbury became a Labour Peer in 1997.

Chairman² and the Chancellor of the Exchequer³ describing themselves as adherents to a social market approach⁴. The focus was shifting towards concern with the goals of social policy, and away from state ownership of the means of delivery. In the SDP we would find ourselves in policy and political discussions with the Conservatives: Owen with the Prime Minister and Conservative Chairman⁵(Owen 1991:790, 802), and myself with the head of the Conservative Research Department⁶. The case that there was a convergence underway upon a new paradigm for public policy seemed strong. The internal market reforms of the NHS, which the SDP had been promoting before the 1987 General Election, were an example of a new approach.

After the 1992 General Election I joined the Civil Aviation Authority (CAA) to assist in the development of new consumer-based policies within the process of market liberalisation, advising both the CAA and the European Commission.. Different modes of policy change seen in Europe and America demonstrated that the process of change can take several forms which are nonetheless transformative.

In America the Airline Deregulation Act of 1978 was a dramatic and complete reversal of preceding policy. It was implemented quickly despite the opposition of the air transport sector, and overseen by Alfred Kahn, who had shortly beforehand been appointed by President Carter to head the Civil Aeronautics Board(Susan 2011). In Europe an incremental process was followed, with piecemeal changes in bilateral agreements between individual countries⁷ and three "packages" towards air transport liberalisation that were agreed between 1987 and 1992, and taken in increasingly significant steps. In the European case this change was achieved despite the opposition of the state-owned airlines and airports which dominated the European market, and of the governments which owned them.

In 1995 I returned to Westminster, as a Special Adviser, to assist a beleaguered Secretary of State for Health in the implementation of policies developed whilst I had

² Chris Patten MP

³ Norman Lamont MP

⁴ Private memorandum "The Social Market", 14 February 1991

⁵ John Major and Chris Patten; 24 February 1991

⁶ Andrew Lansley

⁷ Led by the United Kingdom and The Netherlands in 1984

been working for Owen and the SDP. The political battle over the internal market reforms was still in full flow some five years on, heightened by its inevitable impact on hospital configuration in London. Despite the headline politics, however, the NHS continued to move towards a mixed market of supply, and in several areas towards a predominantly private supply. The Labour Party too, under a new Leader was beginning to adopt a new market-based approach. The surprise was how far they subsequently developed this approach in Government.

Looking back over these experiences it seemed that the biggest parliamentary battles might be fought over policies that touch a political nerve, but that fundamental changes can take place away from these battles, incrementally and often quietly. Taken individually these incremental steps might appear to be little more than politicians muddling along a largely pre-determined path within the political constraints of the day. Over time, however, a transformation might have taken place.

The selection of a research methodology also grew out of my own experiences within the policy process. Not only did I work closely with the leader of an opposition party, but also with several health ministers. It was clear that each of their individual personalities and their relationships with their peers had a significant effect on the policies that were pursued, how they were pursued, and their effectiveness. I have, therefore, sought to gather and analyse the roles that particular individuals played in policymaking. A strong reliance on unstructured interviews and political biographies and autobiographies reflects this belief that personalities matter at least as much as policies. The Italian sociologist Franco Ferrarotti argues that: "The biographical and autobiographical approach, rooted in time, allows the eliciting of problematic human situations and distinguishes radically between the technical problem – resolvable through the exact application of a given, ideally indifferent, and so interchangeable formula – and the human problem"(Ferrarotti 1990:2). However, such an approach focused on the "human problem", if followed in isolation introduces a serious risk of bias and other errors, reflecting subjective accounts of past events: I undertook the research for David Owen's memoirs(Owen 1991) whilst he was still a Member of Parliament. Two insights came from this painstaking work

that would influence my approach to policy analysis. Firstly, the production of autobiographies, and perhaps to a lesser degree, authorised biographies involves recourse to a wealth of documentation that might otherwise never be accessed by researchers, or if they are accessible ⁸ might not be fully understood without the subject's own recollections. The Owen papers, for example, included short notes passed between Government ministers during Parliamentary debates. Secondly, the desire to portray oneself in the best way can impose a heavy bias, and set out an incomplete account of events. In the Owen case, for example, his autobiography makes no mention of his part in arranging the 1978 state visit to London and knighthood for the Romanian dictator, Nikolai Ceausescu. This major event whilst Owen was Foreign Secretary was raised during our work on the Owen book, as Edward Behr⁹ was simultaneously researching his own book on Ceausescu (Behr 1991). In order to compensate for such biases and omissions, the interviews for the research, therefore, extend beyond the policy elite of ministers, to include those behind the scenes in the policy arena at the time of the events under investigation. This, of course, is also enhanced by the usual recourse to the wider, objective literature.

Research Questions

My aim for the research is to test an assumption that health policy exhibits self-reinforcing processes that maintain it on a path established in 1948, and to investigate how specific changes came about in areas that appear to have experienced a change of path. My aim is an improved understanding of a policy process that demonstrates aspects of continuity but also frequent and substantive change.

The research questions that I intend to address are:

- i. Does path dependency adequately explain health policy under Conservative governments?

⁸ Owen's papers are, for example, now held at the University of Liverpool <http://sca.lib.liv.ac.uk/collections/colldescs/owen/index.html> Accessed online 19 September 2012

⁹ Journalist and historian <http://www.telegraph.co.uk/news/obituaries/1552862/Edward-Behr.html#> Accessed 19 September 2012

ii. What are the common factors in the processes of change?

iii. How can theory better explain the NHS policy process?

Scope of the Research

The research aims to determine the forces enabling and limiting policy change. It also seeks to identify the acorns from which new oak trees might have grown, rather than focus on the most obvious features of the policy landscape. Were these acorns planted knowing or hoping for a particular end result, or merely accidental events, and what prepared the environment that they might flourish and last?

This line of inquiry requires both a macro and micro approach. The political and social environment both over time and at the specific points of change is relevant to the analysis. The changes that will be considered are, therefore, set within their context, so that the Conservative approach is traced from the beginnings of the NHS to the 1990s, so that reforms that took place in the Thatcher and Major years are set within their wider context.

This study does not seek to analyse the impact on equity or standards of care, as it is an analysis of the processes of continuity and change and not the outcomes of these processes. The latter topic is, anyway, the subject of considerable and ongoing analysis and debate.

Although the genesis of the research lies in my observations of policy processes in two very different policy areas, as discussed above, the research itself is solely of United Kingdom (largely English) health policy. A similar approach could, of course, be followed in other policy arenas if this might prove to be useful.

Context of the Research

The thesis was completed shortly after the latest major piece of NHS reform legislation had passed into law¹⁰. If it succeeds this will take the NHS another step along the way towards a focus on the local purchasing of care, rather than its

¹⁰ Health and Social Care Act 2012

provision through centralised state agencies. All hospitals will be given managerial independence from government and be subject to the risks of the marketplace. My hope is that this thesis will assist with an understanding of how health policy had reached this point, through an analysis of its past, and provide a framework for predictions of possible future paths that might be followed.

2. Conceptual Framework

Path Dependent or Muddling with a Purpose? Continuity and Change in the NHS

Introduction

The research questions set out in the introduction make it clear that the purpose of the research is to investigate whether the theory of path dependency provides a useful basis for health policy analysis. In this chapter I set out to explain how path dependency has been adapted from economics for social policy analysis, and to consider existing critiques of this adaptation. Whilst path dependency focuses on the self-reinforcing processes that prevent change, I also investigate current understanding of the factors that might generate windows of opportunity (or critical junctures) for a change of path, and the processes that might put particular policies on the agenda when these opportunities occur. The research itself is a study of episodes of change, thus the capacity of the theory to accommodate and explain change, as well as continuity, is of considerable importance.

From Continuity to Change

The Welfare State in England has been subject to constant incremental reform. Change may be taking place in small steps but the scope and nature of the welfare system has nevertheless changed substantially as a result. This raises a range of questions as to why change takes place in this way, whether the path followed is in some way predetermined by history or selected from a menu of options by policymakers at each step, and whether the future shape of the welfare system is predictable. These questions are fundamental to understanding the role of the modern policy process in shaping the future provision of welfare. Policymakers are either constrained to a set path by the exogenous forces of history or are able to engage in transformative changes, whether by large or small steps.

If transformative change has taken place over a period of time, without the major external forces of war or a great depression then a different lens is required. In the

literature there is a tendency to contrast health with other areas of social policy that underwent dramatic changes during the Conservative years, with private sector and quasi-market solutions being adopted in housing, pensions, social care, and education. Pearson, for example, describes the NHS as the one "untouchable" in Thatcher's mission to roll back the state (Cloke 1992:215). This contrast with change in other areas can lead to an assumption of continuity in health policy going back to the 1948 creation of the NHS as a tax-funded universal and comprehensive service.

Despite persistent debate over NHS funding and significant administrative reform, particularly those of the Conservative Government in 1974, the unique UK post-war model survived largely unchallenged until the economic crisis that emerged in the mid-1970s. Since then, however, the nature of the UK health system has changed dramatically. This crisis led the Labour Government to create a Royal Commission to investigate the NHS. The probability of change by the end of the 1970s seemed high, but by no means inevitable. The election of a Conservative government in 1979 further increased this probability. The extent of the change that was to take place over the next 30 years turned out to be substantial. In his review of health policy, and drawing on his 18 years as an Economic Adviser in the Department of Health, Smees concludes that: *"If the NHS in 2005 is compared with the NHS in the early 1980s, one cannot help but be impressed by the scale and radicalism of the policy changes"* (Smees 2005:191).

In this chapter I question the value of path dependency theory adapted to describe the policy process in the modern state. At a time of rather dramatic change in welfare provision, involving widespread retrenchment of state provision and the development of mixed markets of service supply, achieved through processes of constant reform, an approach focused on resilience and continuity struggles to describe current events or provide a basis for analysis. Indeed, by focusing research on institutional resilience and policy continuity a framework of path dependency appears to lead researchers to miss the many smaller changes that take place which, when considered together, present a significant change of direction (Streeck and Thelen 2005). In seeking a conceptual framework for my research I start with the requirement that it must be able to encompass the consistent processes of controversial reforms that have

transformed social policy since the 1980s, beginning with a consideration of how change as well as continuity might be understood within path dependency theory.

Path Dependency: A (False) Dominant Paradigm?

In 1989 the economist Brian Arthur argued that processes of increasing returns played a significant role in determining long-term outcomes between rival technologies, so that economies might be: "locked-in to inferior technology paths"(Arthur 1989: :126). This contrasts starkly with the usual processes of decreasing returns, which allows technological improvements to be adopted and an optimal outcome to be maintained. In his dynamic model "chance" or "historical" events can affect decisions to adopt a certain technology rather than the intrinsic values of the technology. Once adopted, increasing returns strengthen a market position with regard to competitor technology.

Whilst most technologies are subject to constant or diminishing returns, where this is not the case and increasing returns for an existing technology are experienced, laissez-faire policies cannot be expected to produce an efficient outcome given the reliance upon timing and chance events rather than technical advantage. It is important to note, however, that path dependency is not broadly applicable, but appropriate only to cases where increasing returns to a relatively sub-optimal technology prevail. This situation cannot be assumed to exist without evidence showing that increasing returns from chance events are leading to sub-optimal outcomes. Many other factors may be at play including, for example, an incumbent's "sunk costs" that limit opportunities for new entrants and market contestability(Baumol et al. 1982). These can simply be a feature of a particular sector, where market entry costs and risks are high, rather than the result of the timing of past events. The distinction is an important one. In the context of welfare policy the disentangling of feedback effects due to historical legacies, from the current factors and future risks that affect policy reform is essential in order to understand the policy process. Voter opposition to welfare retrenchment appears to be prevalent within all countries, making it difficult to argue that this is a demonstration of increasing returns, given that it is applicable whatever the historical legacy of a welfare state, regardless of the timing and sequencing of events. Indeed, research in behavioural economics has demonstrated systematic "loss-

aversion"(Kahneman 1990), in which significantly higher utilities are attached to losses than to gains of the same magnitude, and an associated "endowment effect"(Thaler 1980) that items are more highly valued once possessed than prior to their possession. Separating the many effects that might limit opportunities for reform and generate apparent path dependency is important to an understanding of the policy process.

Many terms have been adopted into political science from other fields, often with substantive changes to their semantic meanings(Goodin and Klingemann 1996:103). These borrowed concepts include path dependency. The increasing returns that determine path dependency in economics have been interpreted as "*self-reinforcing processes*" that might be perceived in historical institutional analysis.(Pierson 2001:12) The adoption of the theory of path dependency has been rapid within international comparative health policy analysis, to explain the retention of diverse systems in different countries . This has been despite the presence of a long series of strongly contested structural reforms in many systems. Rico and Costa-Font argue that path dependency has become entrenched in social policy analysis largely due to its "intuitive appeal" despite its "dubious conceptual consistency and predictive power"(2005:232-3). Path dependency theory within political science emerged from an increasing interest in historical approaches to the study of political institutions.

Krasner noted in 1984 that there had been a linguistic shift in the literature from Government-based analysis to "statist" analyses, in which government is one of many actors within the policy process in which all actors are constrained by history: "*...once an historical choice is made it both precludes and facilitates alternative future choices. Political change follows a branching model. Once a particular fork is chosen, it is very difficult to get back onto a rejected path.*" (Krasner 1984:225). Pierson argues that this is because path dependent processes affect the preferences of the actors involved in policymaking and the political plausibility of particular reforms.(Pierson 2001:12)

In England, market-based reforms since the 1980s and significant shifts in the public-private boundaries of NHS care mean that the assumption of path dependency can be called into question and explanations sought that may better explain the changes that

have taken place and which may offer some predictive capability for future NHS reforms.

Path dependency theory has provided a useful explanation of policy continuity, but relies on the concept of major and rare “critical junctures” due to exogenous forces to allow for any change of direction. Its apparent strength in the context of policy continuity, based on the role of history and the sequencing of events, is undermined by its inability to provide for major changes to occur through incremental processes. Critical junctures are, therefore, of central importance in fitting analytical approaches based on path dependency to modern accounts of welfare state reform.

Opportunities for change

Drawing on the economic language of “increasing returns”, which can render change ever more costly over time whilst a certain path is pursued, Pierson has explained that: *“Knowledge of the dynamics of increasing returns processes can greatly sharpen our understanding of why particular junctures (and which aspects of them) are critical and why timing often counts for so much in politics”* (Pierson 2000).

In an analysis of welfare state development Esping-Andersen has commented that current theory allows for policy change not through “*mutation*” or the sudden arrival of a completely new solution, but through the “*recombination of old elements*”(1990:124). This recombination takes place at a critical juncture in time, creating a temporary opportunity for a change of direction. It is exogenous forces, therefore, rather than endogenous forces that create these moments in time.

Even when such junctures arise the policy process relies on policy entrepreneurs to seize the moment. These occasions may be predictable, when programmes systematically come up for review, but they may also be unpredictable and arise unexpectedly. Pierson argues that they present opportunities for the interested actors that constantly surround governments, to draw attention to the particular problems in which they have an interest and thus promote their own ideas for solutions. As Kingdon also notes these policy entrepreneurs lie in wait for: *“ problems to float by to which they can attach their solutions, waiting for a development in the political stream*

they can use to their advantage." (Kingdon 1995). According to Kingdon the policy entrepreneurs must be prepared for policy windows to open, if they are not to miss these "windows of opportunity". It is important in the context of the analysis that follows to understand that the Kingdon model of a "policy primeval soup" assumes that the elements for change are constant features in the policy soup, waiting for their moment to come.

Hacker has used a path dependent approach to explain the *historical logic* of the health care systems in Britain, Canada and the United States (Hacker 1998), and to argue against a focus on single variables, whether economic forces, political cultures, or interest groups, which he says has failed to explain long-term divergence across countries in which these forces are very similar. A similar approach was used by Tuohy to demonstrate that the "*accidental logics*" of a system can act as a restraint on both the development and implementation of reform agendas, with very rare windows of opportunity to break with the logic (Tuohy 1999a).

It could be argued that the election of an ideologically-driven Conservative government, led by Mrs Thatcher, in 1979 itself presented such a "policy window", as might any significant election outcome (Garrett 1995). Yet the internal market reforms of the NHS reform were delayed until 1988, still then the ideology applied seemed more linked to efficiency than to any "Thatcherite" concept of privatisation. Similarly the election of a Labour government, after 18 years of Conservative rule, in 1997, with an election campaign largely based on "saving" the NHS, might too have presented a window of opportunity for radical change. Once again any serious attempt at reform was delayed for several years, by which time the window may have closed. These may, however, emphasise the degree to which timing matters. A change of government will present opportunities for change across the policy spectrum, but political priorities will dictate which are pursued. A "critical juncture" is, perhaps, rather more than just a window of opportunity for change, but a decision point when a choice must be made.

The elusive "critical juncture"

In social policy analysis there are significant challenges in attempting to identify "critical junctures" within the path dependency model, even with the benefit of hindsight. Furthermore, it cannot be assumed that a critical juncture, even if it is successfully located, is associated thereafter with the increasing returns processes that are at the heart of path dependency. Pierson has argued, therefore, that critical junctures and path dependence require quite separate consideration (Pierson 2004).

Hogan has attempted to give the critical juncture approach "*a rigour it previously lacked*" (2006:657) by seeking to develop a framework of analysis. He argues that first a "*generative cleavage*" must be evident from examination of the tensions that led to change, and that the subsequent change must be "*significant, swift and encompassing*". It is notable that in seeking to identify path dependency from the starting point of a path rather than the processes that entrench it, the adaptation to social policy analysis bears no relation to any economic concept of path dependency. The significance and speed of the adoption of a new technology have no direct relationship with the mechanism that generates a situation of path dependency and a sub-optimal yet stable outcome. Even the degree to which it might be encompassing, affecting most actors within the relevant market, may only emerge over time. Whilst the framework proposed by Hogan may prove useful in categorising individual episodes of sudden change, it adds little to an understanding of the processes that generate or entrench change. The research to follow will investigate cases where change might not have been swift or even particularly significant and encompassing at the outset, but nonetheless represents a cleavage from the past.

Social policy critiques of path dependency

Ross makes a very strong critique of the adaptation of path dependency to social policy analysis, describing its widespread use as a "*parsimonious model of returns*" (Ross 2007:592). Crouch and Farrell call it "*the new determinism*" because it: "*takes its*

fundamental inspiration from mathematical processes (Polya urn models)¹¹ in which initial conditions may have a determinative effect on subsequent paths of development" (Crouch C 2002), with little allowance for responses to changing circumstances. They note that: "By far the greater preponderance of work in the social sciences has emphasized how institutions may involve 'lock in' – i.e. how they hamper actors in their attempts to respond to changed environmental circumstances, not only including the literature on path dependence, but also some of the sociological literature on embeddedness. When applied too simplistically these accounts underestimate the possibilities for change and innovation."(ibid:5-6). They endeavour to describe institutional change processes within a path dependent environment, but conclude that in the context of complex macro-social phenomena researchers may have to limit themselves to explanation. The "surprising combinations of institutional resources" that policy actors might deploy in order to effect change put prediction out of the reach of researchers(ibid:31).

Bridges argues that the adoption of path dependence from economics for social policy analysis is mistaken because the central mechanism that it relates to in economics, the market, has no equivalent in this different arena. Institutions do not persist simply because of individual decisions to support them, as is the case in economics; when 1980s consumers continued to purchase VHS video format, for example, in preference to the technically superior Betamax. Path dependency in economics is an explanation of an exceptional phenomenon, in which the market appears to allow a stable but suboptimal equilibrium. In social policy, however, it is taken to explain the role of history in institutional stability.(Bridges A 2000)

Peters et al identify an underlying dissensus in apparently path dependent policymaking and identify a role for political conflict in producing policy change over time(Peters et al. 2005), and Glennerster and Lieberman point to elements of UK and US convergence upon a mixed-market solution(Glennerster and Lieberman 2011), which is in direct conflict to Pierson's claim a decade earlier that evidence of radical

¹¹ A statistical process involving the repeated taking of coloured balls from an urn: with two colours, if a ball of one colour is removed (at random) but then replaced with an additional ball of the same colour, this would begin a process of self-reinforcement over time.

change and convergence is limited, due to the existence of path dependency in welfare systems.(Pierson 2001:13)

Critical junctures, which present the only opportunities for significant change within path dependency rely intrinsically upon policymakers opportunities at these rare points in time to select a particular route from those available within Kingdon's "primeval soup" of ideas(Kingdon 1995). In the period of the current research, for example, it might be that the economic crisis of 1976 represented just such a juncture: The end of an era, and the adoption of a new approach to welfare. The response then, however, was to appoint a Royal Commission rather than embark upon a course of enforced, radical change.

Institutional and Incremental Models of the Policy Process

Incrementalism

Understanding how and why specific opportunities for reform arise at particular points in time is important in the analysis of policy systems. Competing models of the policy process accommodate such opportunities to very differing degrees. The traditional **rational model** for example, provides an ideal type of policy making, which assumes an orderly linear process. In such a model new policies superior to those already in place would be found amongst all of the alternatives available and would be readily adopted as part of the routine policy process. As Sutton has commented in an overview of theories of policy process the evidence suggests that this is: "*far from reality*" (Sutton 1999:9). Even the **mixed scanning** model (Etzioni 1967) which involves policy makers in a systematic initial search for all possible policy options before making a more manageable selection of options for more detailed analysis, and from which a final choice will be made, would appear to differ from the reality of decisions taken either under pressure or apparently on the spur of the moment in response to events.

Alternatives that are more accommodating to the complexity of modern political life have, therefore, been developed, seeking to explain policy continuity and change. Incrementalist theories suggest that policy makers find it safer to move forward in small steps, in a process of trial and error in which the political risks are limited, which

might also be seen as a process of simply “muddling through”. Much of the experience of British health policy could indeed be described as muddling through, with very little short-term threat to the status quo.

Lindblom and Woodhouse have explained this approach on the basis that politicians and their policy staff limit themselves to politically-acceptable small changes, knowing that major change would not be supported, and that their own expertise is rooted in the existing system. As a result they naturally restrict their analysis to incremental proposals rather than waste resources on ideas that are deemed to be beyond the bounds of political feasibility, and of which they have little understanding. They also benefit from an incremental approach that minimises the risks from policy mistakes (C. E. Lindblom and Woodhouse 1993).

Whilst this observation might offer a credible explanation of day-to-day health policy making, it cannot provide a useful tool for the analysis of significant policy shifts over time and critical junctures for policy change. In an overview of incremental models, placing them in the context on non-incremental changes, Rajagolan and Rasheed, have traced the development of incrementalism from Lindblom’s original 1959 theory on “The Science of Muddling Through”(C. Lindblom 1959) to the “never-ending bargaining” of “disjointed incrementalism” that he devised with Braybrooke four years later(Rajagopalan 1995).

Institutional Analysis

Path dependency theory is rooted in the analytical tradition of how institutional frameworks over time reinforce past policy choices, thus constraining the policy reform agenda. Proponents of institutionalism argue that the health policy environment is characterised by a particularly strong set of institutions and institutional arrangements that are predisposed to defence of the status quo, and present particularly high and dangerous hurdles for politicians in pursuit of reform. Not only, for example, does the NHS have widespread public support, despite constant public criticism, but its services are provided by professional groups with both considerable political influence and considerable income security. As these forces

might strengthen over time, this might generate an increasingly strong status quo bias and increasing costs associated with radical change.

Developing the institutionalist approach within the context of German health reform Altenstetter and Busse point to a surprisingly consistent path taken by the German social health insurance over a period lasting 120 years. This path was maintained despite dramatic political upheavals with transitions from an imperial regime, to the Weimer Republic, to fascism and war, to national division, and reunification. They argue that the lesson from this is that the German constitution, particularly its federalist provisions, mitigates against dramatic reform. Nevertheless, the authors identify changes in 1993 as a critical juncture because they shifted the balance of power between the institutions within the health system, and that this was reinforced by subsequent legislative measures. The changes were therefore of historical significance (Altenstetter and Busse 2005). By setting changes within their historic context the authors are able to take a view on the significance of an institutional change, assessing both the factors that made the 1993 change possible and its effects over time. This historical approach may overcome a tendency to overstate the importance of recent events and to understate historic events. This may be particularly relevant to the analysis of highly contested policy changes, for which the level of debate might lead to an assumption of importance that is not borne out by its subsequent legacy.

Over time the institutionalist approach has itself been developed and branched. Peter Hall and Rosemary Taylor(1996), for example, identified three “new institutionalisms”: historical, rational choice, and sociological, yet concluded that the three still need to be linked in order to better explain the policy process. *Historical institutionalism*, offers a cultural analysis, in which the institutional environment sets a “world view” that limits policy actors, but which Hall and Taylor claim offers little explanation of what precipitates critical junctures. Within historical institutionalism the state is not a “neutral broker” but is itself composed of a complex mix of institutions with competing interests. This reinforces policy path dependence and can lead to unintended consequences. *Rational choice institutionalism* they describe as a “calculus

rational choice approach". They put Immergut (1992) within this school, as she seeks to explain European health systems on the basis of physicians rationally choosing to strike compromises with reformers. Nevertheless, Immergut herself argues that institutionalism, whilst able to offer generalisations "*cannot produce a science of interest-group influence*", because the factors involved are too complex. She argues that health system histories are replete with "*unexpected events, sudden about faces and new strategies*". Immergut says that major events and everyday problems set the constraints on policy, whilst also serving to generate "*the junctures that extend the limits of the possible*", and thus rejects any view of policy reform that relies upon a single set of factors (Immergut 1992: xiv:xiv). Tsebelis too, emphasises the variety of factors at play, and the many "*nested games*" within which decisions must be taken. Nevertheless, as will be discussed later, he claims that; "*political context and political institutions matter in predictable ways*" (Tsebelis 1990:17) if the analyst is alert to the fact that actors may be playing games in multiple arenas, and if many of the potential complexities of a calculus approach are removed by making a number of initial simplifying assumptions. *Sociological institutionalists* offer a wide definition of institutions, to include moral templates that guide actions, so that: "*Institutions influence behaviour not simply by specifying what one should do but also by specifying what one can imagine oneself doing in a context*" (Hall and Taylor 1996). They thus combine culture and institutions, and argue that individual perspectives of rationality are, in fact, "*socially constituted*" (1996:949). For the sociological institutionalists change comes about when actors and organisations seek to enhance their social legitimacy, leading Hall and Taylor to comment that they see reform as a reality-defying "*bloodless*" process. It would be difficult, however, to consider that the ideological battles over welfare reform during the 1980s and 1990s fit well with such a concept of socially-driven change.

The theoretical models compared

Whilst the incrementalist and institutionalist approaches offer useful insights for public policy analysis, each has its own limitations with regard to this research. The incrementalist approach fails to provide a predictive capability with regard to non-

incremental policy change and, without adaptation, institutionalism can rarely encompass the important role of individual policy entrepreneurs and the changing relationships between them. Yet the current research concerns changes that might constitute a radical change of direction, regardless of whether they were perceived as such at the time. It uses a focus on the policy elite to investigate the role that individuals might play in producing change.

In its attempt to better reflect reality path dependency introduces a high degree of complexity, particularly through the explicit inclusion of timing and sequencing. These temporal factors are *in addition* to those identified in the other models, and a path dependent analysis, for example, needs to be constructed upon a foundation that incorporates the roles of institutions, and policymakers' concerns for political feasibility and risk-minimisation that might lead to change pursued in incremental steps. Whilst challenging, this is very much the ambition of this research.

As Wilsford has observed policy paths are, at least in part, determined by the structures that constrain them, by politics, and by existing technology(1994:256). Path dependency in its analysis of increasing returns processes could provide a useful context for mapping and explaining the continuity of apparently sub-optimal policies, even though it appears to be limited in its applicability to the analysis of a change of path. By understanding the constraints on change the researcher might also be better placed to identify and understand the factors that played a part in overcoming these constraints.

Incrementalism may accurately describe the steady state of muddling through, including *purposeful* muddling with a strategic goal in mind, and institutionalism may offer a useful framework for analysis of the forces promoting and resisting change, but both only develop a capacity to analyse non-incremental change when adapted to incorporate the time and sequence-sensitive elements that are central to path dependency analysis. Events need to be set within their historical and social context if analysis is to present more than a static snapshot of change.

Understanding Continuity and Change

Greif and Laitin make a strong case for the linking of the historical institutionalist and rational choice institutionalist accounts through the use of a game-theoretic approach to explain both continuity and change. (Greif and Laitin 2004). Institutions they say, can be self-enforcing, when the actors involved have no incentive to provoke (endogenous) change. However, "quasi parameters" that are not visible to these actors may work gradually behind the scenes to produce change that would eventually appear abrupt. They draw, for example, on a historical comparison of the powerful and long-lasting late-medieval maritime city states of Venice and Genoa. In Venice the political system embodied in the complex mechanism for the election of a legally-constrained leader (the Doge) served to create a mutual interest in survival that limited clan rivalry, and which made the state self-enforcing, even amidst a decline in external threats and rising prosperity. In Genoa such mutual interest declined once the external military threat declined. Rising prosperity and the loss of a military threat represented positive feedback into the processes of self-reinforcement in Venice, but had negative effects in Genoa, because of the way in which each system had limited clan rivalry. By using case studies of change and a focus on the main personalities involved this research may produce similar comparisons, whereby incentives built into the policy arena might engender instability within a changed external environment.

Historical analysis may be able to identify these "quasi-parameters". Whilst they may have been accorded little relevance in contemporaneous accounts of stability and change, a different importance might be visible over a longer time horizon. Indeed, as Greif and Laitin note, the quasi-parameters that led to change in their study were taking effect long before a seemingly-abrupt change became visible.

Streeck and Thelen note a tendency in political analysis to understate the extent of change and stress continuity, largely due to a lack of appropriate analytical models, and to code all changes as "minor adaptive adjustments" within a punctuated equilibrium model.(Streeck and Thelen 2005:1-2). At a time of incremental but potentially transformative change such models of analysis are too limiting to the researcher, and a focus on "lock-in" effects can miss common types of change. Whilst institutional structures may persist, what they do may change dramatically. Mahoney

and Thalen (drawing on earlier work by Streeck and Thalen) identify four modes of change¹²: *displacement, layering, drift, and conversion*.

Table 1 Modes of Change

Modes of Change				
	Displacement	Layering	Drift	Conversion
Removal of Old Rules	Yes	No	No	No
Neglect of Old Rules	-	No	Yes	No
Changed Impact/Enactment of Old Rules	-	No	Yes	Yes
Introduction of New Rules	Yes	Yes	No	No

(Mahoney and Thelen 2010:16)

Having created this template of four modes of change Mahoney and Thalen suggest a framework of the contexts within which each of these four types of change might be enabled, delineated by the level of veto power for potential defenders of the status quo within the political context, and by the degree to which the targeted institution provides actors with discretion over the interpretation or enforcement of the formal or informal institutional "rules". I shall return to these frameworks when it comes to comparing the case studies of change.

¹² Streeck and Thalen (2005) included a fifth mode of change, of "exhaustion", for circumstances within which a "time-expired" institution is allowed to collapse.

Table 2 Sources of Change

Contextual and Institutional Sources of Institutional Change			
		Characteristics of the Targetted Institution	
		Low Level of Discretion in Interpretation/Enforcement	High Level of Discretion in Interpretation/Enforcement
Characteristics of the Political Context	Strong Veto Possibilities	Layering	Drift
	Weak Veto Possibilities	Displacement	Conversion
(Mahoney and Thelen 2010:19)			

Muddling with a Purpose

It may be, of course, be the case that seemingly erratic and incremental reform trajectories are in fact the result of some strategic purpose. In 1980 Quinn described a process of “logical incrementalism”; a conscious and proactive process within major corporations (Rajagopalan 1995). Summer has alternatively described Quinn’s approach as “*muddling with a purpose*”(Summer 1980).

Looking at changes to the welfare state since the 1980s, the consistency of the direction of change from a comprehensive state monopoly to a more limited mixed-market is striking, under both Conservative, Labour and Coalition governments. The pace of change has varied, or even stalled for brief periods, but there does appear to

have been an overarching logic to it. If governments are muddling through, it does appear that there has been some purpose in their decisions. It may be that, in contrast to the processes of welfare system development, the processes of welfare retrenchment or market-based reform are better suited to gradual change than to major cleavages(Streeck and Thelen 2005:33).

Rajagolan and Rasheed concluded their overview with a call for policy process research to be set within a contextual, longitudinal perspective, in order to reveal the *“complex interplay between the forces of incrementalism and non-incrementalism”* (Rajagopalan 1995). In doing so they refer to work by Ferrarotti (Ferrarotti 1990) in which he argues that change does not emerge from nothing, and that understanding the present can only come from understanding of the past including human factors. To this end Ferrarotti recommends historical research based on autobiography, which is broadly the approach of this research.

Significant shifts can and do occur over time, but it may be that these are often slow because the process is a conservative one, with policy makers moving forward with many small steps rather than sudden leaps and bounds, towards their eventual goal. It may be the case, for example, that the successive NHS management changes of the 1980s, which sought to mimic market disciplines within the public sector NHS were seen by some as essential first, incremental steps towards the development of a mixed market in healthcare. If so, viewed as a whole they may form part of a much larger story of change.

It would appear from this overview of the period that incrementalist and institutionalist perspectives may be able to explain some, but not all, of the experience of health policy under the Conservatives. And it is, perhaps, in the exceptional cases that path dependency becomes more pertinent, setting a context for the various policy streams to merge in order to produce the *“right time”* for a particular policy to be pursued. From his own case studies involving policy in the USA Kingdon(1995), for example, concluded that it is a *“complex combination of factors”* that move an item onto the policy agenda for action, in a process in which even the President himself might not be particularly powerful.

Kingdon adopts Cohen and Olsen's description of an "*organized anarchy*" (Cohen MMJ & Olsen 1972:68). Although originally applied to describe university management, Kingdon argues that it is equally applicable with some adaptations to government, given its often unclear objectives and constantly changing cast of actors. In such organisations choice opportunities come and go, in which the contemporary range of participants become involved with their own haphazard contributions of problems and solutions, which all go into the communal "garbage can" to form a unique mix. It is necessary, however, to build on this in order to provide a more firm conceptual framework for analysis of the specific interactions that take within the garbage can to produce a particular change of path.

The "garbage can" is, perhaps, given more structured analysis in Tsebelis' "nested games" (Tsebelis 1990) rational choice approach, drawing on game theory. Tsebelis assumes rationality on the part of the policy actors, and seeks to explain seemingly irrational outcomes by seeking to identify the "*multiple arenas*" in which the actors must play simultaneously.

The many games in which the actors are playing may not be readily apparent to the analyst. Sartori for example, referred to both visible and invisible politics, the latter of which may be no more than: "*deals and words for mouth-to-ear consumption*" (Sartori 1976:143), and related this to Downs (Downs 1957) assertion that parties devise policies to win elections, rather than vice versa. Politicians must, therefore, constantly seek to square the circle between their ideological commitments, which they might share with their active supporters, and the potentially differing views of the electorate. The timing of politically dangerous policies is of crucial importance: many commentators, for example, have noted that Mrs Thatcher's review of the NHS was announced following the 1987 general election rather than before or during the re-election campaign, and the subsequent reforms were rushed in order that they would be in place before the Conservatives next faced the electorate.

Problems, Politics & Policies

Kingdon identifies three streams in the agenda-setting process, that can combine to present opportunities for change: problems, politics, and policies. In this model, therefore, the institutions that generate pressure for and against change may be placed within the policies and politics streams, but share these streams with other influences on the agenda-setting process. He argues that the streams need first to be understood individually, which then allows for analysis of policy change when the streams come together to create a “*policy window*”. Tuohy also attempts to isolate the forces leading to episodes that might break from the historical logics of a health system, arguing that willing and able actors for change must be present and that there must also be a widely established priority for reform (Tuohy 1999). These are similar to the roles that Kingdon gives to policy entrepreneurs awaiting the convergence of the three streams to generate a window of opportunity for a new policy to be put on the agenda for decision.

In the case studies I have adapted Kingdon's concept of streams to map the forces leading to specific policy decisions, although these individual decision points do not fit the standard description of a critical juncture, as they each relate to just one small aspect of the overall health system. My approach to the research is focused on the actions of the policy elite and for my purposes, therefore, Kingdon's "politics" stream is concentrated to focus on the political actors in power, which I refer to as "People". The broader political environment involved in agenda setting is captured in the narrative around each case.

Hacker has argued that it is important to understand that path dependency and critical junctures are not synonymous terms: “*path dependence is best suited to explaining the reproduction of a critical juncture’s legacy rather than the production of the critical juncture itself*” (Hacker 1998:78). As mentioned earlier, many social policy researchers appear to seek to identify critical junctures from which path dependency can then be assumed.

In testing the applicability of path dependency to English health policy there may also be some value in looking again at its origins in economics. As the concept has moved further from its original base for adaptation to social policy it may also have lost aspects of its analytic value. Health system expenditure is a significant aspect of fiscal policy, and in looking at micro and mezzo-level policy changes it would be worthwhile incorporating economic factors as variables for analysis. Sunk costs, opportunity costs, and barriers to entry, may play an important part in the formation and outcomes of any windows of opportunity for reform.

Using three streams of people, problems, and policies across a diverse range of developments in UK health policy under the Conservatives may assist in bringing comparability and structure to the cases. In doing so it may be possible to determine, for example, whether changes in dentistry and long-term care were simply incremental, or whether the emergence of specific policy windows, due to an identifiable merging of the three streams, enabled an observable and determined change of path.

From very different starting points health systems may be converging steadily towards a common format, equivalent to economic convergence, on the equilibrium of a mixed market model. In a comparison of changes in the US and UK health systems Glennerster and Lieberman warn against excessive reliance on path dependence and in favour of a more detailed analysis of *"micro- or mezzo-level mechanisms of policy change"* (Glennerster & Lieberman 2011) which may overtake longstanding historical logics. Tuohy attempts to allow for such convergence between healthcare systems that nevertheless have their own "accidental logics", the incorporation of which are crucial to successful policy change. She argues that whilst path dependence may emphasise national differences, broader technological changes and other micro- and macro-economic developments, may generate *"some broad cross-national similarities in the interactions of actors"* within the logics of the local environment, and the processes of change(1999a:260-1).

Path dependency and the modern NHS

Griffin recommends counter-factual interrogation of history as an analytical tool (Griffin 1993). If 1948 or 1976 might have been critical junctures for English social policy then it may be useful to interrogate the possible alternative scenarios. Can it be assumed that if a Conservative government had been elected in 1948 that a continental social insurance model would have been developed? Or that if a Labour government had been re-elected in 1979 that the NHS would not have taken the path of retrenchment and towards a mixed market?

After September 1976, the economic and industrial crisis in which Britain was engulfed and the terms placed on the country in return for a \$2.3bn loan from the International Monetary Fund left no scope for welfare expansion. Indeed, the then Labour Chancellor told his party conference that the country may have been living on borrowed time since the war. Timmins describes this moment as *"the first great fissure in Britain's welfare state"* (Timmins 2001:313).

At that time the major ideological divide on the NHS was between the continued phasing out or the maintenance of private beds ("pay beds") within NHS hospitals. It was not until the 1980s that experiments with market-based social policy reforms began to be developed. Harrison identifies the management reforms of the mid-1980s as the possible turning point for UK health policy, as they: *"led to important structural, political, and interpretive changes within the NHS and laid the foundations for the formulation and implementation of the more radical, market reforms a few years later"* (M. Harrison 2004:32).

In 1992 Pinker described these social policy experiments as: "a fundamental reappraisal of the ends and means of social service provision" in which "all the political parties continue to revise their basic policies in a climate of changing needs and expectations dogged by an economic crisis which seems likely to persist well into the 1990s" (Pinker 1992). Almost a decade later Pierson wrote of a "new era of austerity", to which research into the "golden age" of welfare growth bears little relevance (Pierson 2001:2)

If there has been no critical juncture for the welfare state since 1976, how then can its transformation from a comprehensive state monopoly to restrictive provision within a mixed market be explained? This conundrum lies at the heart of the research. If the NHS at the time of writing is so fundamentally different to the NHS of the 1970s there must have been points in between at which significant new directions were taken.

Whilst the research is framed within the theory of path dependency it should prove useful to also possess an understanding of the most relevant alternative explanations of the policy process.

Theoretical Models and the NHS under Thatcher and Major

One example of the importance of history and timing that will be explored is the way in which the perceived failures of the Heath government of 1970-74, within which Thatcher was a minister, drove the "No Turning Back" agenda under Thatcher; a determination that affected a wide range of policies. Similarly, the Conservatives' strong support for the British Medical Association in opposition to Bevan's NHS Bill cast lasting seeds of distrust over the Conservatives' handling of health policy, perhaps generating some degree of self-reinforcement for the Bevan model. Both examples emphasise how the sequencing of events matters, as does the timing of change: The NHS "internal market" emerged from the 1980s as a possible solution to a perceived problem in the operation of the NHS, the solution was not timely until Mrs Thatcher unexpectedly announced a review of the NHS during a BBC interview in 1988. Until then the solution had largely been floating in what Kingdon refers to as the "policy primeval soup"(1995:116). In 1988 it was an idea whose time had come. If, however, the review had taken place before general management had been developed in the NHS the outcome might have been very different. Timing and sequencing may indeed have been crucial to the policies that emerged.

The role of a large majority in the House of Commons, and implicitly therefore the British "first past the post" electoral system that provides such majorities on a minority vote, is accorded an important role by Ham, who argues that Mrs Thatcher's parliamentary majority was essential in order to "drive through" the internal market

reforms. Walt(Walt 1994:226) applies a similar logic of government strength to the sudden introduction in 1984 of a “Limited List” of pharmaceutical products to be removed from NHS reimbursement. Whereas Walt does not specify the source of government power at the time, Ham argues that even the most powerful of pressure groups are unable to defeat the proposals of a strong-willed government in such circumstances(1999:49), although the veracity of this claim will be tested in the case studies that follow. Hill comments that in such an ideologically-driven situation as existed in 1980s Britain the debate between rationalism and incrementalism is “*beside the point*”(1997: 108) as traditional processes are set aside.

In contrast to his claim of governmental determination on the internal market reforms, Ham also states that the Conservatives allowed NHS dentistry simply to wither away, by failing to respond to dentists’ own decisions to withdraw from NHS service, and that long-term care was withdrawn “*through a series of incremental decisions*” (1999:94). According to Ham, therefore, the Conservatives maintained a traditional incremental approach in most areas of health policy, based on negotiations between the administrators and service providers, in a process of “partisan mutual adjustment”, as identified by Lindblom, and that even in the introduction of the internal market the change may have been organic, having been based on the earlier Griffiths management reforms of the 1980s, and then significantly diluted to become a “managed market”.

Incrementalist approaches give helpful insights into specific incidents of gradual changes and movements along a path, but appear to be less helpful in the analysis of small changes that cumulatively result in a change of path. A process of incremental but significant change seen over a period of years and decades cannot be explained by power-based theories if parliamentary majorities and government authority are seen to fluctuate over the full period of observation. These theoretical models appear insufficiently flexible to deal with the changed circumstances of the 1980s, which combined large elements of continuity with elements of radical change.

Conclusion

Whilst analytical approaches focused on continuity may be appropriate in times of welfare system development, with major changes taking place at major junctures followed by incremental change along a predetermined path, processes of change through piecemeal retrenchment and reform may require a different conceptual framework. The changed environment following the financial crisis of the 1970s has received renewed emphasis in policy analysis following another crisis in the first decade of the 21st century. This had led to widespread questioning of longstanding theories of the policy process given an apparent increase in the frequency of radical change, against the focus on continuity of incrementalist and institutionalist theories(Cairney 2012).

An interaction of levels of analysis may be required. Ham argues that; *"studies of specific policy issues need to be related to the action and inaction of structural interests and the changing role and functions of the state if a complete understanding of the complexities of health policy is to be obtained"* (Ham 1999:217). The approach taken in this research aims to integrate data from specific incidents of change with data on the wider policy arena in order to better understand the process of transformation.

In the context of transformative institutional change outside of circumstances that might ordinarily be considered to be "critical junctures" a clear analysis of the relative roles, if any, of institutional self-reinforcing processes and endogenous forces for change is required. At present the tools for analysis lack predictive capability with regard to institutional change given the reliance upon unexpected and unpredictable exogenous forces. Current research into broad aspects of change by Streeck, Thalen, and Mahoney, for example, particularly into the characterisation of forms and circumstances of change provide a strong starting point. Tuohy's comparative analysis of health system reforms also offers some specific consideration of the factors that may provoke or enable change within the complex and sensitive context of health policy. This body of work provides a useful framework

for my analysis, towards an improved understanding of why and when change might happen.

Using an adaptation of Kingdon's three streams as a basis of analysis will enable comparisons to be made between the reinforcing processes of historical logics that keep a health system upon a particular path and the micro and mezzo-level forces for change in specific aspects of the health system. It will also enable the approaches taken by Kingdon and Tuohy to be tested against quite detailed changes in the English health system, rather than simply addressing the health system at the macro level. Tracking the changes of the 1980s and 1990s, by tracing their origins back through the preceding decades may also assist in identifying consistent trends, and perhaps intentions, in pursuit of reform.

Importantly, the conceptual framework for the research seeks to identify the role that ideology played in the process of change. Taken together, was the process of the change under the Conservatives a form of purposive muddling or simply disjointed incrementalism? Is there an identifiable and logical series of steps towards an end goal, or simply a set of individual policy responses to individual problems? An element of purpose and strategy would undermine the depiction of path dependency as a self-reinforcing process which only a significant exogenous shock can halt. As in Greif and Laitin's research it might even be the case that the actors who produce change are not themselves even aware of the quasi-parameters that incentivise their actions, thus evidence of strategic intent might need to be drawn from actions rather than words.

The research takes as its starting point the observation that since the 1980s financial responsibility for a wide range of aspects of healthcare has fallen onto individual households. In some cases the boundary in the provision of care has shifted as well as the boundary of its finance. Increasingly market mechanisms were being used to deliver services that had been the exclusive domain of the state for the previous 40 years. These are dramatic changes that break with the original conception of the NHS, furthermore they mimic "quasi market" approaches taken in other policy areas (Le Grand 1991), which highlights the importance of using a framework of analysis that sets each detailed change within its wider context. The subsequent

analysis does not attempt to address the welfare impact of these changes, nor the ethical questions that relate to any redrawing of the scope of the welfare state. The focal point of the research is the identification of the factors that have produced dramatic changes within such a totemic part of British social policy, described by a Conservative Chancellor of the Exchequer of the period as: "the closest thing the English have to a religion, with those who practice in it regarding themselves as a priesthood" (Lawson 1992:613).

3. Research Methodology

The research employs a qualitative approach. Using contemporary accounts, later autobiographical material, official publications and Hansard, and peer-reviewed literature. These are supplemented with a series of interviews with important actors from the policy arena, and five case studies of change. It seeks to build a comprehensive narrative that combines macro and micro perspectives. In doing so across both a general depiction of the contemporary scene and a selection of individual cases of change the intention is to achieve Griffin's aspiration for narrative-event structure analysis; to develop a coherent "story" that unifies a range of happenings (Griffin 1993:1098).

Searches of peer-reviewed literature, therefore, cover analysis of the Conservative approach to health policy in general between 1979 and 1997, the development of the NHS "internal market" reforms announced in 1989, and the five case studies. In order to capture the wider context and the role of individuals in the policy elite peer-review literature is substantially supplemented by recourse to grey sources, particularly biographical sources where these are available.

A series of 15 loosely structured interviews were undertaken¹³, in which the interviewer sought only to prompt relevant narratives from the interviewees. These prompts included an introduction to the topic and a request to identify key events in the case study topics. Narrative interviewing can be particularly valuable in research that seek to combine life histories with socio-historical context (Schutze 1992) (Jovchelovich 2000). In order to better understand motivations and the multiple arenas within which policy is made socio-historical context is important to the research. If policy is formed by rational choices amongst the policy elite then an understanding of the "nested" games within games that politicians must play, and the roles of some of them as "veto players" in the policy process is essential (Tsebelis 1990).

¹³ An additional interview that has not been included here was undertaken in October 2004. This was specific to the case study on NHS dentistry and is, therefore, cited only in that chapter.

The overall approach taken in this study is similar to that of Horowitz et al., in their study of policies to tackle health disparities. They used a combination of literature reviews and informal interviews (Horowitz et al. 2000). It is also similar to the methodology adopted for Kendall's study of agenda-setting processes related to the voluntary sector, in which the author combined the literature, "including a wide range of low-visibility grey literature from the third sector itself", with a small number of interviews to address the broad themes of his inquiry but tailored to each interviewee (Kendall 2000). Kendall was thus able to incorporate data on the working relationships between those involved in the policy process to obtain an improved understanding of the factors involved in a process of change.

The Literature

The relevant literature for the research encompasses both the political environment, the Conservative approach to health policy, and the background to specific cases of change. The research relies heavily upon archival, autobiographical, and biographical sources; an approach recommended by Ferrarotti in order to better understand the human elements of the historical environment (Ferrarotti 1990). The use of a range of grey sources in addition to peer-reviewed and official data should enable accounts to be cross-checked and discrepancies addressed. Although the release of official documents through National Archives is currently limited to those from 1981 and earlier, some useful additional documents were available from the Thatcher Foundation archive. Official sources used included the Hansard records of Parliamentary Debates, government policy documents and press releases. Histories of the NHS and the welfare state by Glennerster(1995), Klein(2001), Rivett(1998), Timmins(2001), and Webster(Webster 1998) provided important accounts, as did Raison's history of the Conservative Party and the welfare state(1990).

Case Studies

In order to investigate the specific factors involved in episodes of health policy change the research includes five case studies in which there was either a shift of the public-private boundary or an attempt at such a shift. The purpose is not to provide a

comprehensive account of each case, but to understand the environment within which the change happened, the factors involved, and to be in a position to compare these micro-level accounts of change with the mezzo-level perspectives from the interviews and background material. The mechanisms used to achieve change are important as well as the factors that make it possible, as the mechanisms used may further our understanding of how any forces for continuity are overcome in practice. According to Little an approach based on "causal realism" in which causal mechanisms are identified enables the researcher to investigate the external validity of the causal factors involved: If A leads to B within a case study, an understanding of the causal mechanisms involved provides some insight into whether the relationship between A and B will hold in other situations (Little 1996:34). The use of multiple cases should also enhance the external validity of the research findings, at least within the health policy arena.

Gerring commends the use of case studies for exploratory work, for example when some or all of the factors involved in a phenomenon might be unknown. Study of a single or several cases may produce factors that might not be otherwise identified, making the quantitative analysis of known factors within a large-scale cross-case analysis inappropriate. In this situation case study allows the researcher to "*peer into the box of causality*" (Gerring 2007:45).

The first stage of the research was to search the literature for accounts of health policy development across the 18 years of Conservative government from 1979 to 1997. Whilst much of this commentary focuses on the internal market reforms introduced from 1990, it also yields a selection of specific areas in which there were significant shifts towards individuals paying for their own care, and the development of market mechanisms in the delivery of state-funded care. The shift of long-term care of the elderly from the NHS to means-tested social care, and the burden of charges for dentistry, sight tests and medicines are cited most frequently as examples of areas in which costs have shifted to users. Further investigation into these areas of policy reveals additional evidence of shifts in both finance and provision. Dentistry, general ophthalmic services, and medicines were all subject to radical policies that set boundaries on the responsibilities of the NHS, often for the

first time in an otherwise comprehensive service. They conform with Gerring's definition of "*crucial*" cases, because they are the examples that seem initially at least unlikely to fit within the conventional view of a health system that is seen by many to be locked into a path-dependent policy process (Gerring 2007:89).

The use of case studies, of course, has its own pitfalls. In particular, there is considerable ambiguity in the definition of a case study (Mitchell 1983). This lack of clarity is addressed by Verschuren in his advocacy of case studies not as a defined research method but a complete research *approach* with its own methods, techniques and procedures and complementary to other approaches (Verschuren 2003). Determination of the spatial or temporal boundaries of a case is rarely simple, and relies upon a degree of judgment on the part of the researcher.

Use of a range of cases addresses the most significant concern related to case studies, that it is unwise to generalise from a single case with an assumption of "typicality" (Mitchell 1983:189). A single and isolated case of an aspect of the NHS that breaks from an historic policy path would add little to our understanding of the policy process. If, however, a range of crucial cases shows some commonality in the mechanism of change, this may well offer insights into factors relevant to the wider policy environment.

The case studies are selected from those that appear to be the best examples available that show, over time and with the benefit of hindsight, instances of a significant change of direction. This might be despite the degree of significance not always being apparent at the time. Indeed, as mentioned above, in several of the cases more attention in the literature is given to NHS charges than to new limits on NHS responsibilities that might have an increasing effect over time.

In order to fulfill the research objective to identify the factors and mechanisms involved in episodes of change the focus is on the time at which the change of direction appears to have been made, rather than produce a detailed commentary on its subsequent implementation and effects. Gerring highlights the fact that it is often the situation that either the temporal or spatial limits of a case may be difficult

to define, yet needs to be assumed for the purposes of research.(Gerring 2007:19-20). In each case, therefore, the author has attempted to identify the period over which the process of an actual change of direction is achieved, and to separate this from the continuous processes thereafter by which it is reinforced. This is necessarily a subjective judgement. Just when an idea originates, with whom, is difficult to determine hence what constitutes the "beginning" of any such account is problematic.

A fifth case study, not mentioned in the list above is also included in order to provide analysis of a change that had little effect in practice and which ultimately proved to be a temporary phenomenon rather than a lasting new direction. This was the introduction of tax relief on individual purchases of private medical insurance by people aged over 60 years. The inclusion of this policy change further maximises the heterogeneity of the cases, and enables a comparison to be made between those changes that became entrenched and one that was readily curtailed and reversed. In summary the five cases and the reasons for their potential significance are listed below:

1. **A market for general ophthalmic services.** The introduction of free eye tests and spectacles had been a notable, popular and controversial feature of the 1946 NHS Act. (Webster 1988:369-75). In 1983 the Government not only restricted the right to NHS spectacles, but removed a ban on advertising and thus enabled competition between opticians. The NHS subsequently withdrew from the market for spectacles with the introduction of a voucher scheme for the private purchase of spectacles, and restricted access to NHS sight tests. In the light of the debates in the first five years of the NHS this was a highly significant set of changes.

2. **The development of private long-term care of the elderly.** Until the 1980s long-term care of the elderly had been shared between long-stay geriatric wards in NHS hospitals and care provided by local authority social services department. The 1983 change in

Supplementary Benefit regulations put public funds into a rapid expansion of private sector care. What had been a rare exception quickly developed to be a much more common option, and cost limits had to be imposed in order to contain the situation, but it was not until the Griffiths Report of 1988 that the Government developed a concerted strategy for “community care”. By the late 1990s residential care for the elderly had moved from being primarily provided by local authority owned and staffed institutions to privately owned and staffed ones(Glennerster 2009).

3. The creation of a "Limited List" of non-reimbursed Medicines. Until the 1980s the principal and most visible policy to contain the public cost of prescription medicines had been the flat-rate prescription charge. Once more, it had been highly controversial in the late 1940s and early 1950s. The charge was more than doubled by the Conservatives in 1979, from 20p per prescription to 45p. Still NHS doctors retained clinical freedom in what they prescribed. This unexpectedly changed in 1984, with the introduction of a “Limited List” of non-prescribable items. This change paved the way for subsequent national policies to restrict NHS prescribing on the basis of clinical evidence and cost. It can thus be seen in retrospect as a very important change.

4. Tax relief on private medical insurance. Rewarding those who purchased private medical insurance has long held a totemic status within the Conservative Party. A tax relief for employer-provided insurance was re-introduced in 1980 to put it on a par with other "perks", but it was the proposed extension of tax relief to individually-purchased policies that was to reignite the issue as a topic of heated debate, both within the Conservative Cabinet and between the Government and Opposition following the announcement of the relief in 1989. It was abolished in 1997.

5. **Growth of private adult dentistry.** Throughout the 1980s NHS dental charges faced by patients rose significantly, but the growth of private adult dentistry was concentrated in the 1990s following changes to the NHS dental contract and the development of an insurance system for private dental care alongside rapidly rising NHS costs. The new situation was finally addressed in 1996, when the Government and dental profession agreed a contract that would concentrate NHS dental funding on children whilst attempting to provide a nationwide safety net for adult dentistry.

These cases have been mostly neglected by academic analysis of the policy process, although all were heavily debated at the time (Rivett 1998; Webster 1998). Parliamentary discussions and media reports provide most of the historical data for this aspect of the research. Where these examples are mentioned in political autobiographies then the reporting can be combined with an “insider” account, although this is usually very limited given the limited historical profile of some of the individual changes involved. This is, therefore, combined with interviews in order to obtain additional insights from those who were either involved or followed the policy processes of the time.

Interview Selection

The author had himself worked on health policy, first for the Social Democratic Party in opposition from 1987 to 1992 and thereafter within Westminster think-tanks, and from 1995 to 1997 served as Special Adviser to the Secretary of State for Health. The knowledge of the policy arena that this gave was useful in the selection of potential interviewees. These were to be people who possessed a good knowledge of the periods of change, and who might provide novel insights into the factors at work in decision-making. The interviewees include two former Conservative Secretaries of State for Health and two former Conservative ministers. In order to balance any potential bias in the account that reliance upon ministers alone might generate, the remaining 11 interviewees were drawn from a range of backgrounds. The approach taken contrasts sharply with those of other authors, such as Ham, who have focused

on Secretaries of State for Health to explain health policy of this period(Ham 2000). The latter approach can too easily succumb to politicians' tendency to rewrite their own role in history, to produce a positive reflection of their time in office. It also tends towards a headline-driven analysis, as this represents the bulk of the work of a Secretary of State, and much of the underlying detail can be missed. The inclusion of a junior minister and a Minister of State who would have had lead responsibility for some of the case studies also assists in overcoming the tendency towards headline-driven commentary. Both of the Secretaries of State, however, had also served as junior health ministers and one had also been a Treasury minister. At the time of the interview one was still active in the health policy elite, as Chairman of the House of Commons Health Committee, whilst the other was now a member of the House of Lords but working principally outside of health policy. The other interviewees are drawn from as wide a range of the policy elite as might still fall within that description. All of the interviewees are listed below.

Interviewees

Professor Nicholas Bosanquet. A founder member of the research staff at the highly influential Centre for Health Economics in York, from 1984 to 1988. He later became a Professor of Health Policy based in London, and since 1988 has been an advisor to the House of Commons Health Committee. His advice on NHS reform has been regularly sought by Government ministers and advisers, particularly during the development and implementation of the internal market reforms.

Rt Hon Baroness Bottomley DL. An elected member of the House of Commons from 1983 to 2005, when she became a Member of the House of Lords. She was a Minister of Health from 1989 until she was appointed Secretary of State for Health in 1992, moving to the Department of National Heritage in 1995. She was, therefore, an important decisionmaker throughout the main period of the development and implementation of the internal market reforms, with which she is commonly associated. In 2007 she joined the Board of the private health care business BUPA.

Edwina Currie. A Member of Parliament from 1983 to 1997. She was a health minister from 1986 to 1988, spanning the 1987 General Election (including the change of Secretary of State from Norman Fowler to John Moore) and the development of the Ministerial Review of the NHS. She famously resigned her ministerial post following her outspoken comments relating to salmonella in eggs. Since 1997 she has pursued a broadcasting and writing career outside of politics. At the time of publication of her diaries (Currie 2002) she revealed details of a four year affair with John Major, the future Prime Minister, whilst he was a Government Whip.

Rt Hon Stephen Dorrell MP. An elected member of the House of Commons since 1979. He was closely associated with the left of the Conservative Party during the 1980s, and only held junior offices until John Major became Prime Minister. He remains Patron of the left-leaning Tory Reform Group (TRG). He was made a health minister in 1990, moving to the Treasury in 1992 (responsible for public spending), and was Secretary of State for Health from 1995 until the Conservative election defeat of 1997. In 2010 he became the first Chairman of the Health Select Committee to be elected by his peers.

Dr Michael Goldsmith. A former General Practitioner, Goldsmith created the Harrow Medical Centre, which was Britain's first private primary care centre working on a pre-paid subscription rather than a fee-for-service basis. This reputedly provided an important inspiration to policymakers for the market-based reforms of the NHS in the 1980s and thereafter. His advice was sought by the Prime Minister, ministers and their advisers during the 1980s and 1990s. He now runs a private-sector occupational health consultancy.

Dr David Green. A former Labour councillor, Green was based at the free-market Institute of Economic Affairs (IEA) from 1984 to 2000, and for most of this period was Director of the IEA Health and Welfare Unit. Since 2000 he has been Director of the think tank Civitas. At the IEA he was an important figure behind the consistent pressure on the Conservatives to adopt voucher schemes and private market solutions in the provision of welfare services.

Professor Walter Holland An epidemiologist who, inter alia, served as a Department of Health specialist adviser since 1969, including as a member of the Resource Allocation Working Party (RAWP) that fundamentally changed the funding mechanism of the NHS in the 1970s. Since then he has served on local and national NHS bodies covering a wide range of policy challenges. He is now a Visiting Professor at the LSE. His is an extraordinary perspective of NHS change over more than 40 years.

Melinda Libby A Special Adviser to Rt Hon John Moore MP from 1988 to 1989, when he was Secretary of State at the Department of Health and Social Security, which included the early stages of the Ministerial Review of the NHS. Moore had previously been responsible for privatisation policy, and was widely seen at the time as the most likely heir to Mrs Thatcher and her policy approach. Libby, therefore, can be expected to have special insight into a very important period of health policy, yet is largely independent of Moore and the Conservative Party. As far as the author is aware she has never previously commented on her time working closely alongside Moore, and it took a degree of research to track her down to the school of which she is now a Governor.

Warwick Lightfoot. An economist, and former Special Adviser to the Chancellor of the Exchequer, and later Leader of the London Borough of Kensington and Chelsea. John Major says that when he was appointed Chancellor he was keen to retain Lightfoot, who had been appointed by his predecessor, describing him as an "excellent technician".(Major 1999:135)

Gerald Malone. The professional life of Malone has encompassed roles ranging from editing two national weekly newspapers, to Minister for Health, a government Whip, and Deputy Chairman of the Conservative Party(1992). He was a Member of Parliament from 1983-87 and 1992-97, and was the Conservative candidate in the 1982 Hillhead By-Election against Roy Jenkins.

Cllr Keith Mans. A former RAF pilot, Mans was a Conservative Member of Parliament from 1987 to 1997. He served as a ministerial Parliamentary Private Secretary in the

Department of Health from 1990 to 1995, providing an important link between the Minister and the Parliamentary Conservative Party during the implementation of the NHS "internal market" reforms. After leaving Parliament he became Chief Executive of the Royal Aeronautical Society, and is now Chairman of a hospice in Hampshire, where he is also a County Councillor.

Rt Hon Lord Owen CH. A Member of Parliament from 1966 to 1992, during which he was a Labour health minister and foreign secretary. In 1981 David Owen became one of the "Gang of Four" who created the Social Democratic Party (SDP), of which he later became leader. Owen was heavily influenced by the European "social market" approach to policy and became a keen advocate of market-based policies in general, and in 1987 was already arguing for an "internal market" for healthcare, including the incorporation of private and voluntary providers into the delivery of NHS-funded care. In 2012, however, Owen attacked his earlier advocacy of the mixed market, in the face of a Health and Social Care Bill that had developed out of this earlier change.

Clive Smee CB. Chief Economic Adviser in the Department of Health from 1984 to 2002, encompassing the whole period of the Conservatives' market-based health reforms, and the adoption of a similar approach by the Labour Party in 2001. Prior to joining the Department of Health he had also worked in HM Treasury and the Cabinet Office. His independent insight into the Whitehall policymaking processes relevant to this research is probably unmatched. He is the author of a book on the changing role of economic advisers in government. (Smee 2005)

Rt Hon David Willetts MP. He rose to prominence in the early 1980s, initially as an official in HM Treasury, before his 1984 appointment to the Prime Minister's Policy Unit in 10 Downing Street. He moved out of Government in 1987 to run the Centre for Policy Studies, which had been created by Margaret Thatcher and Keith Joseph in the 1970s. He was elected as a Member of Parliament in 1992, and has since served in several Ministerial roles and played an important part in Conservative Party strategy. Since 2010 he has participated in the Coalition Cabinet as a Minister of State.

Professor Roger Williams CBE. A liver surgeon, who has been an important figure in the Conservative Medical Society (CMS), of which he is President, since its formation in the 1980s. His role at the CMS has made him a confidante of Conservative health ministers and their advisers over several decades, particularly during the reforms of the 1980s.

Six attributes were used as selection criteria for interviewees, with the intention of ensuring the dominance of no single perspective.:

1. Secretary of State for Health; Virginia Bottomley and Stephen Dorrell. In order to obtain the perspective of health policy debate at Cabinet level, including of debates and strategies between competing departments and between the Department of Health and the Treasury it was essential to include at least one Secretary of State in the interviews.

2. Health Ministers. Ministers outside of the Cabinet would have specific departmental responsibilities, including most of the negotiations with the health institutions outside of government. This detailed knowledge of health policy is useful to dual level research including case studies of specific changes. Virginia Bottomley, Edwina Currie, Stephen Dorrell, and Gerald Malone all served as Conservative health ministers. Additionally, David Owen was the Minister of Health in the Labour Government of 1974-79

3. Strategy Advisers. Those who advise ministers, whether in an official capacity or not, can provide a useful source of knowledgeable commentary on policy development and the people involved, with unique "behind the scenes" insights, and operating as "policy entrepreneurs". As well as the author of this research, Melinda Libby served as a special adviser to John Moore, the Secretary of State at the Department of Health and Social Security during 1987-88, when the ministerial review of the NHS began. Keith Mans served as Parliamentary Private Secretary to Virginia Bottomley throughout her time as Secretary of State for Health,

providing an important link between the Department and the Conservative party in Parliament. Additionally, David Willetts was an adviser at 10 Downing Street and Warwick Lightfoot at the Treasury. Michael Goldsmith acted as an unofficial adviser to 10 Downing Street, and to several Secretaries of State for Health, as did Roger Williams as Chairman of the Conservative Medical Society.

4. Treasury Experience. Health is an area of significant and growing spending and is, therefore, a constant concern of Treasury ministers. This was reflected in the composition of the 1988 ministerial review, which included two Treasury ministers and one health minister. Stephen Dorrell was Financial Secretary to the Treasury before returning to the Department of Health as Secretary of State. Warwick Lightfoot as a special adviser to both Nigel Lawson and John Major whilst they were Chancellor of the Exchequer.

5. Medical Advisers: The interface between health policy is central to the policy process, given the constant negotiation between the professions and the politicians. Independent expertise plays an important role in decisionmaking. Walter Holland has provided medical expertise to policymakers over many years, Michael Goldsmith played an important part in the development of the primary care elements of internal market reforms, and Roger Williams on secondary care.

6. Commentators. Health policy is conducted in a very public arena, and interviewees with an understanding of perspectives outside of Whitehall are of value in providing breadth to the data. Currie, Malone, and Lightfoot have all had careers in national journalism, and Bosanquet has long been involved in providing expert commentary, including advice to the Health Committee of the House of Commons.

Conducting and Analysing the Interviews

Informal, unstructured interviews are best suited to situations in which the interviewer is unable to know the most relevant questions in advance, as is usually the situation in exploratory research (Berg and Lune 2012:110-111). As the purpose of the research is to identify the factors at play in health system changes, a prescriptive set of questions within a programme of structured interviews would run the risk of failing to elicit factors that might be unknown in advance. Furthermore, comments in early interviews may suggest factors worthy of investigation in subsequent discussions, so that the interviews themselves may well be adapted as the research progresses.

Reik has described a role for the interviewer as a choreographer "*listening with the third ear*" (Reik 1948), constantly reflecting on interviewee comments, and adapting as necessary to control the interview, drawing on the interviewer's own intuition and insights. It is in this role that the prior knowledge of the interviewer plays an important part.

The interviews were conducted in locations most suitable for the interviewees, ranging from offices to public spaces. One interview (Currie) was conducted by telephone. The author's intention was that the interview environment was as amenable to relaxed conversation as possible in order to obtain open commentary on the issues. Indeed, most of the interviews began and concluded with informal conversation which, although irrelevant to the research can be a powerful incentive towards the building of a degree of rapport between both parties. Berg and Glassner successfully used informality and rapport-building in order investigate the very sensitive topic of alcohol drinking habits amongst Jews in New York City. Indeed, they were so successful in this that several of their interviewees commented that they would not have spoken on the topic so openly with their own friends and family (Glassner and Berg 1980:651).

All of the interviews were digitally recorded and the interviewees' contributions were subsequently transcribed. The duration of each interview was between 30

minutes and one hour. The transcripts were then coded to separate data relevant to each case study, the internal market, and the political environment. "Non-indexical" data containing value judgements and generalised commentary was also retained as this "life wisdom" might prove relevant to the eventual analysis as part of a combined macro-micro research strategy(Jovchelovich 2000:69).

Ethics

All of the interviews were digitally recorded with the interviewees agreement. The time lapse between the interviews taking place and submission of the thesis raised the possibility that interviewees' views on the topic may have changed, or their level of political sensitivity changed. Although only one interviewee requested sight of any direct quotations before publication all of the interviewees were provided with a copy of the transcript of their contribution to check. In recognition of the privileged nature of some of the interviews, the long time scale over which they took place, and the risks to interviewees the transcripts themselves cannot be published.

Author Involvement

As has been mentioned previously the author of this thesis was closely involved in aspects of health policy during the period of the research. In the latter half of the 1980s he was involved in national policy discussions within the Social Democratic Party (SDP), and from 1990-92 he served as Research Assistant to the former Health Minister and then SDP Leader, Dr David Owen MP, who was an early advocate of the "internal market" reforms of the NHS. During this work with Dr Owen he also played a central role in the development of the Social Market Foundation think-tank in Westminster, which was very active in the health policy arena at the time. From 1995-97 he served as Special Adviser to the Secretary of State for Health, and was closely involved in debates and decisions over the NHS "internal market" and more specifically on policies relating to the case studies of this thesis.

This level of personal involvement clearly presents both problems and opportunities for the research, and is not unusual within a relatively small policy arena. A similar situation was faced by Oborn in a study of the role of policy entrepreneurs during

the development of health reforms for London (Oborn et al. 2011). The risk of author bias is significant, but it is hoped that the research design can overcome this as much as possible, and as in the Oborn case mentioned above the benefits to the research can be significant. Indeed, it is highly unlikely that without this involvement the selection of interviewees could have been so broad and novel. The insights brought to the research by the inclusion of Mans, Libby, Goldsmith, and Williams, for example, are unlikely to have been sought without a first-hand understanding of their significant roles behind the scenes of policymaking. The selection of case studies covers a range of policy areas, some of which will have seen author involvement, but others which predate his activity in the health policy arena, broadly from the time of the 1987 General Election campaign onwards. The research methodology relies heavily upon literature sources, official records, and political memoirs, with the interviews providing supplementary, reminiscent data. It thus combines both positive, factual accounts and normative assessments. This combination should mitigate the effects of bias emanating either from the author or the interviewees.

The research opportunities arising from author involvement are considerable. Firstly, a broad prior knowledge of the topic enables an approach that is alert to the wider political and social circumstances of the time. Secondly, his close involvement has provided insights that have made it possible to cast the net for potential interviewees much wider than would be the case for a researcher less closely involved in policymaking, through a detailed understanding of the range of people who might carry influence and of those who have rarely reported perspectives on policy change. Thirdly, it raises the likelihood of productive interviews as political interviewees are more likely to present a relaxed and open narrative when discussing past policy decisions with someone who is already known or even allied to them.

4. The Conservatives and the NHS 1944-74

In order to better understand boundary changes that may have taken place under the Conservatives from 1979-97 an analysis of the Party's historic approach to policy on the National Health Service will provide useful context, and offer insights into the forces shaping a Conservative approach. Only by doing so is it possible to understand whether reforms under the Thatcher and Major administrations constituted new directions in health policy, or whether they sit within an historically-consistent strategy. This is relevant not only to the general approach taken which is considered here, but also to the specific cases of boundary change during the Thatcher and Major years that will be separately discussed later, namely dentistry, long-term care of the elderly, ophthalmics, pharmaceuticals, and private medical insurance. In order to avoid repetition events involving the case study areas are only covered in this and the subsequent chapters if they are of wider historical or contextual significance, in order to reserve a more complete commentary for the dedicated sections.

As explained earlier the research methodology used draws heavily on personal accounts from some of the major players, often from their memoirs or biographies. As previously mentioned this approach, focused on autobiography, is recommended by Ferrarotti, as a means to using subjective accounts to better understand historical events rather than rely purely upon a factual narrative (Ferrarotti 1990). Such sources should assist in detecting whether internal forces associated with the NHS limit or enable change, as expected from the self-reinforcing processes that are central to path dependency theory, or whether external factors play a more significant role in policy outcomes. A degree of analysis of the decades leading up to the 1979 to 1997 extended period of Conservative government will provide useful context for the analysis.

For the purpose of discussion the Conservative approach to the NHS from its creation to the fall of the Heath government in 1974 has been separated into three discrete periods: the debate around the creation of the NHS in 1948 under a Labour government; the unbroken 13-year period of Conservative rule between 1951 and 1964; and the Conservative government of 1970 to 1974 led by Edward Heath.

Aside from the return to a Labour government in 1974, this year represented a turning point for the NHS and for the Conservative Party. It was the year in which the first major structural reorganisation of the NHS took place, but which then became a regular policy option for ministers in the decades that followed. It was also the year in which the Conservatives lost two General Elections under Heath and began to look for a new approach to politics. A "New Right" was emerging within the Conservative Party, with its emphasis on individual freedom and a limited state (Taylor-Gooby 1981). One leading exponent, Keith Joseph, denounced "*thirty years of socialistic fashions*" (Joseph 1974), embarked upon a policy review and created the Centre for Policy Studies, with Heath's approval, to promote the "*counter revolution*" (Harris 2011:478-479).

The rise of a "Thatcherite" approach thereafter is dealt with in a separate chapter covering the path followed until the 1988 Ministerial Review of the NHS, that led to the 1989 White Paper "*Working for Patients*". (Dept of Health 1989b).

Developing the National Health Service

The theoretical foundations of a Conservative approach could be traced back to the inter-war years. An academic backlash to collectivism in Europe and elsewhere was underway. The Austrian "classical liberal" economists Von Mises and Hayek began to exert influence on alternative policy thinking at this time, following their respective moves to America and Britain. Hayek's students at the LSE included Arthur Seldon, who was later a founder of the Institute of Economic Affairs (Cockett 1994:22-24).

The 1942 Beveridge Report, which laid the foundations of the modern welfare state, whilst popular with the public, caused considerable disquiet amongst Conservative MPs, which was reflected in a confidential report to the Party's policymakers planning their post-war agenda, warning not only of the costs of universal social security, but also its impact on individual liberty. (Cockett 1994:61-2). The Conservative Chancellor of the Exchequer in the wartime coalition warned Churchill that Beveridge's plans presented "*an impractical financial commitment*". (Raison 1990:5) Formal groups were formed within the Conservative Parliamentary Party,

including the Progress Trust and the Tory Reform Group respectively to oppose or lend support to Beveridge. The former included Henry Willink (Cockett 1994:67-68) who became the coalition Health minister during the war, after his predecessor's plans for a National Health Service, which included unifying all health services at a regional level and bringing general practitioners into a salaried service, ran into strong opposition from the British Medical Association (BMA). (Raison 1990:8).

After successfully steering Britain through World War II, in 1945 Churchill led the Conservative Party to its worst defeat in almost 40 years, winning just 213 seats in the House of Commons for his party and its allies. Labour won 392 seats. The Conservative historian Harris has described how: *"In every sense that mattered, the 1945 election marked a great shift leftwards in the British polity"* (Harris 2011:373).

The importance of the creation of the NHS remains a topic of considerable dispute. It can be argued that post-war welfare state legislation represented a major juncture in policy, or that it was an incremental development from the Beveridge report. Glennerster, for example, describes 1945 as *"merely a staging post"* within a pre-existing process of welfare state development, albeit with a "coherent and long-lasting institutional legacy". (2000:2-3). Indeed, in the months leading up to the July 1948 creation of the NHS the Labour health minister Bevan had been arguing that his proposals were a natural development from preceding policies with broad support:

"The history of the Health Service Act is a very long one. It started with the National Insurance Act in 1911–12. Then in 1920 there was the report of a committee under Lord Dawson. Then in 1943 it was revived, and in 1944 there was a Coalition White Paper. Then there were protracted discussions with my predecessor" (Hansard 9 February 1948).

Rivett's history of the NHS demonstrates how centralised approaches to welfare had gathered cross-party support during the war, exemplified by the 1944 Goodenough Report on a system for medical manpower planning (Rivett 1998:13), and the 1946 creation of the National Blood Transfusion Service (Rivett 1998:12); as examples of

how the war was influencing the country's social development. According to Rivett: "*the war had increased the sense of social solidarity and many saw the advantages of a command structure*" given that military personnel in particular had received better health services during the war than they had previously.(Rivett 1998:27). Furthermore, the war had also demonstrated the feasibility of a national health service through the creation of the Emergency Medical Service (EMS) under which the state took charge of hospitals and directly employed doctors in order to provide a managed service to the sick and wounded of the war(Titmuss 1950).

Whilst the balance of archival evidence may now show that the voluntary hospitals were indeed in declining financial health (prior to widespread state support through the EMS), driven by a changing social environment and rising costs (Gorsky et al. 2002), this was by no means clear to those debating the creation of the NHS after the war. Indeed, even at the time of the creation of the EMS the government's analysis was that voluntary hospitals deficits may have been little more than cyclical features, concentrated in London teaching hospitals, and in some cases due mainly to poor management(Gorsky et al. 2002:535). Other topics of debate have been the degree to which state funding crowded-out voluntary support in 1938-39, and whether the deficits that were incurred at that time were exacerbated by hospitals scaling up in anticipation of state support under the EMS.(Gorsky et al. 2002:539)

Klein, however, argues that a degree of "*consensus*" on a revised health system had developed in the years between the creation of a national insurance scheme in 1911 and the outbreak of World War II(Klein 2001:2-3), particularly as the voluntary hospitals increased their financial reliance on charges to their patients(Webster 1988:4).

Whilst the Labour government of 1945 might have willingly followed a consensus on the general direction towards creation of some form of national health service, its specific proposals to do so proved highly divisive. The preceding Coalition policies had, anyway, been vague on detail (H. Jones 1992b:10). According to Clark's history of the Conservatives, by the Spring of 1945; "*Labour effectively detached itself from any cross-party consensus on 'Medical Reform' and signalled that an incoming*

Socialist government – at that time thought unlikely – would play a free hand on this topic"(A. Clark 1997:252). This contrasted with the bipartisan approach that produced the Education Act of 1944, that created a free schooling system based on a partnership between the Minister, local education authorities, and the voluntary sector (mainly churches).(Raison 1990:11)

The Conservatives, as mentioned previously, had been divided on the development of universal social security. Churchill had neglected the development of clear post-war policies, not least by closing down the Conservative Research Department (CRD) for the duration of the war (Cockett 1994:75). Jones too has demonstrated that any appearance of consensus may have been little more than superficial given the underlying concerns within the Conservative Party (H. Jones 1992a). Pimlott has also firmly rejected the notion of a post-war consensus(Smith 1988).

The Conservative Party policy adviser of the post-war period, Michael Fraser¹⁴, has also rejected the notion of a cross-party consensus:

"The two main parties coming out of the coalition government in 1945 had already hammered out, not without some hard bargaining and horse-trading, the broad policies for dealing after the war with those social problems that had been identified and prepared for during the war on the basis of the Beveridge Report, the Employment Policy White Paper and the Butler Education Act of 1944, there was for a time an unusual degree of apparent unity of aim. To say, however, that the situation after 1945 amounted to a 'consensus' is a myth of more recent origin. No one thought that at the time. The real position was like that of two trains, starting off from parallel platforms at some great London terminus and running for a time on broadly parallel lines but always heading for very different destinations"(Hennessy and Seldon: : 310-11: quoted in Raison (1990):15).

¹⁴ Lord Fraser of Kilmorack (1915-1996). Joined the Conservative Research Department in 1946. Deputy Chairman of the Conservative Party 1964-75. House of Lords 1974-96 (Patrick Cosgrave, 'Obituary: Lord Fraser of Kilmorack', *Independent*, 4 July 1996 1996.)

The ideological divide between the Conservatives and Labour was significant. The Conservative Party, for example, donated one-and-a-half tons of its paper ration to the publisher Routledge to enable a reprint of Hayek's *"The Road to Serfdom"* (Hayek 1944), which warned of the possible adverse consequences of collectivism, to coincide with the 1945 General Election (Cockett 1994:93). Churchill's attacks on socialism during the General Election were soon afterwards described as a *"diatribe"* by the young Conservative MP Quintin Hogg (Hogg 1947:228).

The Conservatives faced a post-election dilemma in confronting the inevitability of the creation of Bevan's plans for a National Health Service. They struggled to maintain a policy of support for the British Medical Association (BMA), whilst trying to avoid being too closely associated with it in its intransigence on co-operation with the new health system. It was expected that most doctors and dentists would, in fact, choose to participate in the new system come the appointed day, and the BMA position not to do so posed great risks for the party. The Parliamentary Party was, therefore, advised by its policy secretary (Iain Macleod) to concentrate its attacks on Bevan himself (H. Jones 1992b:150). Nevertheless, voting against the NHS at all stages of its progress through Parliament presented a great dilemma for the Conservative Party given the popularity of the project. One Conservative MP told the House of Commons in the Third Reading debate that they would vote against it; *"with a sense of very real regret that we cannot conscientiously support the Bill as it is now"*. (Raison 1990:18)

The debate over the new NHS became heated and personal. In February 1948, after the legislation had passed, the Government sought a debate in the House of Commons to attack both the Conservatives and the BMA for their opposition to the new NHS, and to which the Conservatives could offer only a muted response. Bevan told the Commons:

"What we do take serious objection to is to organised sabotage of an Act of Parliament. We desire to know from the Opposition whether they support that. Do they support the B.M.A. organising resistance on 5th July, because I would warn them that the beginning of that road might look very pleasant

but the end would be exceedingly unpleasant, not only for us but for Members opposite."(Hansard 9 February 1948: Col 49).

As Klein observes: *"The consensus may have provided a foundation. It did not provide a blueprint"* and the proposals created *"conflict within consensus"* that was to become a consistent characteristic of NHS policy making.(Klein 2001:5) Whilst the 1944 Coalition White Paper had left open the possibility of charges for health services under the new system(Webster 1988:56), Labour's proposals expressly ruled charges out. As will be seen this was to become a very persistent source of debate.

The health minister, Aneurin Bevan, was determined to nationalise the hospitals and create a universal service free at the time of need. His policy was, therefore, one of considerable centralisation. Rather than give a significant role to local authorities Bevan opted for a regional system of administration, in order to provide executive control for hospital planning(Rivett 1998:28). According to Harris the NHS that was created in 1948 was: *"significantly different from anything that a Tory-led coalition, let alone a Conservative government, would have introduced"* but the Conservatives had failed to set out their alternative by the time that Bevan presented his Bill to Parliament, which left a *"poisoned legacy"* for the Party thereafter on its approach to the NHS(Harris 2011:368). Again, this was to become a persistent issue in the decades to follow, between centralisation in pursuit of equity and decentralisation and local flexibility.

Writing in 1947 Quentin Hogg MP (later Lord Hailsham) claimed that: *"in almost every sphere of national policy Labour social policy was based on the motto "Divide and Rule",* arguing that the Conservative scheme for the new NHS *"would not have found it difficult to avoid antagonising all the great professions and institutions through whom the service, whatever its nature, would have to be carried out."*(Hogg 1947:255). It would be ironic, therefore, that forty years later the Conservatives would incur the wrath of the health professions and institutions whilst returning managerial autonomy to hospitals. According to Hogg the Conservatives in power would have followed a similar approach to that taken in 1944 in the Education Act: *"using existing machinery and leaving with localities a free responsibility and a great*

measure of freedom of policy – but welding the whole into a general plan in which general standards were enforced, but in which diversity and variety were reconciled with efficiency and the ultimate control by Government of quality" (ibid)

Care of the elderly also came under the spotlight at the end of the war, with the beginnings of a shift towards the provision of measures to provide the elderly with independence rather than be left untreated in long-stay institutions. The first geriatric services were established in 1948-9 (Rivett 1998:75-6) and the old Poor Law system of local support for those in need was replaced in the 1948 National Assistance Act with a new centralised system of cash payments. The local authorities, however, retained responsibility for welfare services, which would include the provision of old people's homes to replace the workhouses. The original intention of this dual system was that the level of non-means tested retirement benefits paid would be sufficient to cover subsistence costs. According to Timmins the fact that they were not, and were also poorly indexed attracted little attention at the time; "But the impact of the decisions was profound and forms part of the next fifty years' history of the welfare state" (Timmins 2001:136-7).

Taking up the Reins: 1951-64

By the time of the election of a Conservative government three years after the creation of the NHS, the service was already proving to be a substantial, and apparently unexpected, financial challenge. According to Campbell the miscalculation by Bevan and officials in the Ministry of Health on the costs of the new service became immediately apparent in 1948 (Campbell 1987:180). This had already led the Labour Government to undermine its earlier commitment to a free service when it legislated in 1949 to enable the implementation of a charge for prescribed medicines, although it did not actually impose a charge. The Conservative opposition had also taken the opportunity presented during the passage of the 1949 NHS (Amendment) Act to argue for steps to encourage growth in the private health sector. (H. Jones 1992b:156) and in 1950 the Party set up a committee to investigate ways to cut the cost of the NHS and encourage private care. Proposals considered by the Lucas-Tooth Committee included subsidies for patients to offset any price

difference between their choice of a private bed and the NHS alternative¹⁵.(H. Jones 1992b:157). Then in 1951 the Labour Chancellor of the Exchequer, Hugh Gaitskell obtained Cabinet approval for charges for dental and optical services (Klein 2001:26) which were announced in his Budget in April (Webster 1988:176).

The first Conservative Minister for Health following the 1951 General Election, considered not only charges but also the almost total abolition of the General Dental Service, although the Cabinet eventually opted to implement only a prescription charge and a flat-rate dental charge(Webster 1988:189). A focus on post-war house building added to the pressure on all other aspects of social spending given a manifesto pledge for 300,000 homes to be built each year in pursuit of a "*property-owning democracy*", placing housing second only to defence in public spending. With regard to education and health, the manifesto simply said that: "*for the money now being spent we will provide better services and so fulfil the high hopes we all held when we planned the improvements during the war*"(Conservative Party 1951)

For the next four years the Conservatives put the question of the NHS to one side. In 1952 the Government created the independent Guillebaud Committee to investigate the costs of the NHS, which reported four years later. The Committee's economic analysis, carried out by Titmuss and Abel-Smith, showed that the real-terms costs of the NHS were in fact less than often thought, and falling as a proportion of GDP(Abel-Smith and Titmuss 1956). Although the Committee's final report largely endorsed the status quo, including the recently-introduced prescription charge (Ministry of Health. 1956), according to Klein it also heralded the end of "*health care utopias*" based on an assumption that health gains would make the *service "self-liquidating"*(Klein 2001:27).

The Guillebaud Report effectively tied the government's hands on reforming the NHS, leading ministers to claim that all it really required in 1956 was "*time to settle down*"(Webster 1988:107). By this time the Ministry of Health had declined in stature; it was no longer a Cabinet post and had become something of a "*revolving*

¹⁵ This was a policy to which the Conservative Party returned in 2003, with proposals for a "Patient's Passport".Cpu, 'Setting Patients Free [Electronic Resource] : A Conservative Policy Consultation',

door" for ministers(Klein 2001:32). The exception was Iain Macleod, who remained in post for three years but who had, upon his appointment, declared a period of "tranquility" for the health service (ibid). This approach largely reflected the wider aspirations of the government. Churchill was 77 when re-elected and, according to Harris, had "*finished with taking risks, or at least any that seemed avoidable*"(Harris 2011:387). Nevertheless, appointing such an independent committee to investigate the costs of the NHS had been a political mistake by the Treasury in response to Macleod's wish for a Royal Commission with a much wider remit, covering the whole of social service spending. As the Chancellor's wish to further undermine the potential for political criticism of the Government's intentions by appointing a leader for the review who "*would confound the critics*"(H. Jones 1992a:320). Instead the review confounded the wishes of those who appointed it.

The best the Conservatives could do after the Guillebaud Report, amidst internal discussions of a switch to a social insurance scheme, was to increase dramatically the allocation to the NHS from the National Insurance Fund(Webster 1998:37). In a review of Churchill's peacetime government from 1951 Harris draws comparison with later Conservative administrations: "*An opportunity was...missed. A comparison of 1951 with 1979 and Margaret Thatcher – and in a different way 1970 and Edward Heath – is perhaps illuminating. On each of these occasions an incoming Tory government was faced with the choice between holding power and using it. Churchill chose to simply hold it. Trying to do more, even with a slim majority, was not impossible*"(Harris 2011:387-88).

Nevertheless thinking within the Conservative Party and academic debate on the size and operation of the welfare state continued behind the scenes. In response to continued weakness in attacking Labour on the welfare state, opposition Conservative MPs decided to create the "One Nation" group, choosing social services as the topic for its first pamphlet, and in 1954 publishing the politically provocative book "*Change is our ally*"(Powell et al. 1954). In 1950 Richard Law MP, for example, had published "*Return from Utopia*" (Law 1950) which, according to Cockett, "*became the gospel of post-war liberal Conservatism*. Enthusiasts for this new "social market" approach as an alternative to collectivism included Diana Spearman and

Enoch Powell, of the Conservative Research Department.(Cockett 1994:98-99), drawing on the earlier work of Hayek and Robbins. Cockett claims that it was at this point that the "*seed for the future blossoming of economic liberalism*" had been planted (ibid). Hayek's Mont Pelerin Society (MPS) of like-minded economists centred on the LSE, Chicago and Vienna had become an important forum for the development of liberal economics. In time it attracted the attention of Conservative researchers and parliamentarians, including Geoffrey Howe, Enoch Powell, Keith Joseph, and Edward Heath (Cockett 1994:118-119), and in 1955 the Institute of Economic Affairs (IEA) was created to further improve the dissemination of these ideas amongst policy entrepreneurs(Cockett 1994:132). Ironically, it was Powell, as health minister, who announced a major state hospital building programme in 1961, albeit alongside large increases in the NHS Contribution from the National Insurance Fund, the prescription charge, dental and optical charges(Webster 1988:37).

For all the theoretical debate around the margins of the Conservative Party, however, the thirteen years of Conservative government between 1951 and 1964 can be described as a time of "*enviable organisational tranquillity*" for the health system(Glennerster 2007:83) although Labour's 1964 election manifesto referred to it as "*thirteen wasted years*"(Labour Party 1964). For all its optimism for action on social policy based on expectations of strong and consistent economic growth, reflected in the removal of prescription charges in 1964, the economic environment for the Labour administrations of 1964-70 quickly turned hostile, and the charges were re-introduced in 1968 following the devaluation of sterling in late 1967(Webster 1998:71). Labour also faced serious difficulties in restraining public sector pay, as part of its programme of spending cuts; not only across the generality of the nationalised industries and public services, but most particularly in the NHS, where pay reviews led to recommendations for 20 and 30 per cent increases for nurses and doctors respectively for 1970(Webster 1998:72).

Economic Crisis 1970-74

Much as the Conservatives could have supported the Labour Party's efforts to weaken the unions in 1969, it chose not to do so, possibly for fear that this would

undermine the Conservatives' anti-union political advantage, and their emerging plans for a package of legal measures of their own (Howe 1994: :47). The economic situation, industrial relations, and plans for joining the European Economic Community were the main interests for Edward Heath, the new Conservative Prime Minister, in 1970(Layton-Henry 1980:169). Whilst Heath was elected on a manifesto that carried much right-wing ideology it was rhetoric in which Heath never himself believed(Young and Trewin 2009;109). Nevertheless, Heath's failure to follow up on the rhetoric was to subsequently take on an importance that was to profoundly influence the direction of the Conservatives under its next leader.

According to Harris (2011:470-475)Heath governed in three phases. The first, until 1972, saw a focus on tax cuts and public spending control, and the introduction of the Industrial Relations Act which imposed legal duties on trade unions in collective bargaining agreements and the conduct of strike ballots. At the beginning of 1972 unemployment reached one million and a miners' strike was underway, and the second Heath phase began as he resorted to spending increases, incomes policy, and industrial support in an attempt to boost the economy. After settling one miners' strike with a substantial pay increase, another soon followed. The Yom Kippur war and an Arab States oil embargo led to dramatic rises in oil prices, that pushed Heath into his third phase, with an emergency budget in December 1973 to produce cuts in public spending. Heath responded to the miners' February 1974 decision to strike with an energy-saving three-day working, and then with a General Election, which brought a minority Labour government to power.

The Heath government may have begun with plans to alter the basis of the welfare state, as reflected in the October 1970 Budget, which the Chancellor introduced talking of a more selective approach (Timmins 2001:280), but this rhetoric quickly changed. Keith Joseph, the Minister of Health and Social Security, had been an enthusiast for moving the NHS to a social insurance scheme, but in office was persuaded that such a change would not be worthwhile as the state would still bear much of the cost(Timmins 2001:291).

Instead Joseph embarked upon a strategy of increasing NHS funding in general, and for the more neglected services in particular, and upon a large and rapid NHS reorganisation. This was intended to unify hospital, primary care, and local authority services, and to deliver management efficiency. Joseph was guided by external management consultants, hoping to create a health system that could be planned from the centre, and was able to deliver on those plans. The reform was announced in a White Paper in 1972(Parliament 1972), attracted little media comment(Rivett undated), was legislated for in 1973, and its implementation was rapid in order to fit in with a local government reorganisation also planned for April 1974(Timmins 2001:294-295). The reorganisation saw the number of administrators in the NHS increase rapidly from 70,000 in 1971 to 98,000 in 1976(Cabinet 1978).

Following the Conservatives' electoral defeat in 1974 Joseph expressed regret that he too had succumbed to "socialistic" fashions: " We have overestimated the power of government to do more and more for more and more people, to re-shape the economy and indeed human society, according to blueprints. We have tried to take short cuts to Utopia. But for lack of a really good map, because we were in too much of a hurry, we have finished up further away than ever. In the social services, alas, we seem to have generated more problems than we have solved."(Joseph 1974)

In 1974 the radical analysis that had been first presented in the 1945 Conservative manifesto, based on Hayek's "*Road to Serfdom*", and promoted for the preceding two decades by the Institute of Economic Affairs, now found a group of frontline proponents within the Conservative Party, spurred on by a bruising period in government.

5. The New Right 1974-1987

This chapter highlights the significance of the rise of New Right¹⁶ philosophy in response to the perceived failure of Heath to stand firm on both the management of the economy and confrontation with the trade unions. The experience of 1970-74 and the Conservative Party's rejection of the old consensual form of politics typified by Heath was to dictate the Party's direction under Margaret Thatcher, in opposition until 1979 and thereafter in government. An approach based on Kingdon's policy streams will be used to map health policy changes from 1979, and the contents of the streams of problems, politics and policies can be traced back to this period: The serious problems in public expenditure and industrial relations that emerged under Heath were going to come to a head under Labour, marking the beginning of a new era of austerity in public services. Thatcher and her allies within the Conservative Party were to develop as a serious political force, and in 1975 a search for radical policies based on a rethinking of the role of the state began.

Commentary and analysis of health policy under the Conservatives led by Margaret Thatcher has a tendency to take a short-term view, treating the Thatcher years from 1979 as an entirely new direction (Mohan 1995). But, as already shown, the Conservative market-based approach of the 1980s has roots that extend to the period before the 1948 creation of the NHS, and which also owe much to the "New Right" approach that became central in Conservative policymaking after its 1974 defeat, although it had been present within the Party since the 1960s..

In 1969 the Party Leader, Edward Heath used well-publicised shadow cabinet brainstorming sessions at the Selsdon Park Hotel to debate the Party's agenda, this included discussion of several radical briefing notes and ideas¹⁷. This led Harold Wilson to describe the Party's direction saying: "*Selsdon Man*¹⁸ is designing a system of

¹⁶ The term "new right" will be discussed later in the chapter

¹⁷ The agreed policies were less radical than often portrayed, as the Party was by no means widely committed to a change of direction. Timothy Raison, *Tories and the Welfare State: A History of Conservative Social Policy since the Second World War* (Basingstoke: Macmillan, 1990) 218p.:69

¹⁸ Presumably a reference to Piltdown Man, reconstructed in 1912 from fossil finds in a Sussex gravel pit, and thought to be the "missing link" in human evolution. This was proven to be a hoax in 1953.

society for the ruthless and the pushing, the uncaring. His message to the rest is: you're out on your own" (Harold Wilson 20/02/1970).

Thatcher recalls: "Selsdon Man won the 1970 election on a radical Conservative manifesto" (Thatcher 1993:13). Indeed, the later 1979 manifesto was rather low key in comparison despite the radical government agenda that was to follow: In 1976 Chris Patten, Director of the Conservative Research Department (CRD) had suggested that for the next election the Conservatives would have a "*common sense*" manifesto with less ideology than in 1970 (Young and Trewin 2009:95) despite the new Leader's commitment to an ideological agenda.

In 1973, following Heath's failure to consistently pursue the Selsdon agenda in government, the right-wing Selsdon Group of MPs was formed to build the Conservative commitment to pursue the free-market ideology set out in the 1970 manifesto. A similar concern to pursue the new approach led Keith Joseph to establish the Centre for Policy Studies (CPS) in the mid-1970s, with Thatcher as its Deputy Chairman (Thatcher 1993:13-14). The CPS played an important role in the entrenchment of a "new right" agenda within the Conservative Party (Jenkins 2006:40-41) and the spectre of Heath's policy about-turn influenced much that was to follow within the Conservative Party over the subsequent two decades.

From Heath to Thatcher (via the IMF): 1974-79

When Edward Heath finally faced a leadership election in February 1975 following the loss of two elections in 1974 the ideological divisions within the Conservative Party came to the fore, and Heath suffered an unexpected defeat by Thatcher on the first ballot, when many had assumed that she was merely a "stalking horse" preparing the way for more established candidates in the second ballot (Jenkins 2006:45). She only decided to stand when Joseph had to concede that he would not, following a furore following a speech on social policy that he made in Birmingham (Thatcher 1995:266). Her first-round success is often attributed to the tactics employed by her campaign manager, Airey Neave in strongly downplaying Thatcher's own prospects so that MPs could vote for her safe in the knowledge that other candidates would take over in a

second round of voting. In fact, such was her first round success that any other candidate stood little chance of stopping her (Cockerell 1988:217). This was, according to Thatcher, "*a shattering blow*" to the Conservative establishment(Thatcher 1995:277). One of Thatcher's first acts was to appoint Joseph as Chairman of the Conservative Party's Advisory Committee on Policy(Layton-Henry 1980:18).

The five years from 1974 to 1979 was a period of great political division over the NHS. Legislation to quickly remove private beds (known as "pay beds") from NHS hospitals, and which was announced in November 1974, has been described as a "*sacred mission*" for Barbara Castle, Labour's Secretary of State for Health and Social Services: "*It was the means whereby she would redress the historic error of her hero, Aneurin Bevan*"(Owen 1991:233). This battle between the major parties over the existence of a mixed public-private market within the NHS was to remain a point of contention into the next millennium.

More generally, the Labour government elected in 1974 faced early difficulties, given the economic circumstances of the time and ongoing industrial unrest. The NHS pay bill increased by more than 20 percent in its first year(Webster 1998:75), at a time when public spending needed to be cut in order to meet the demands of foreign lenders supporting sterling and the British economy. The Chancellor had already told the new Cabinet at its third meeting, in March 1974, that the country faced its worst-ever peacetime economic situation, with high inflation and a £400 million balance of payments deficit(Castle 1990:432), and in March 1975 the Cabinet was warned of a £1 billion cut in spending programmes for 1976-77(Castle 1990:584). In July 1975 the Cabinet agreed to an emergency statement setting out a firm "*reversal of policy*" to target a rapid cut in inflation by pay and price limits (rather than further spending cuts) in order to steady the foreign exchange markets and stave off recourse to an IMF loan which would be tied to spending cuts(Cabinet 1975). The then Chancellor later described himself as an "*eclectic pragmatist*" in his abandonment of a reliance on Keynesian demand management policies (Denis Healey 1989:383), and claimed that in 1974 the Treasury had been "*the slave*" to Keynes(Denis Healey 1989:378). As the economic situation worsened the Treasury's planned spending cuts rose to £5 billion by October 1975. For the health services the Government's reduction plans in the

February 1976 White Paper concentrated on NHS capital spending, proposing to reduce expenditure in this area by more than a third from its 1974 peak.

In November 1976 the Chancellor of the Exchequer, in preparation for an IMF loan agreement, explained to the Cabinet that reducing the Public Sector Borrowing Requirement would now need to come primarily from spending cuts rather than tax rises, and that inflation would need to be tackled through the money supply rather than pay and price controls (Cabinet 1976). The Cabinet thus adopted a monetarist approach to economic management, and the Chancellor wrote to the International Monetary Fund (IMF) on 15th December 1976 formally requesting long-term financial support for the British economy¹⁹, and offering to go further in reducing the Public Sector Borrowing Requirement (PSBR) if required, telling the IMF: *"The United Kingdom government will consult the Fund ...on the adoption of any measure that may be appropriate"* (Dennis Healey 1976:12). Harris asserts that: *"the real turn-around in economic thinking came about not in reaction to Heath but in consequence of the International Monetary Fund intervention in 1975-6"* (Harris 2011:481).

In fact, the Labour Chancellor of the Exchequer, Healey, had already in 1975 taken many of the steps that would be required by the IMF in 1976. And in September 1976 the new Prime Minister (from April 1976), James Callaghan, told the Labour Party Conference: *"We used to think that you could spend your way out of recession"* (Finlayson A undated). Callaghan recalls that he was already *"deeply convinced of the need to win the battle against inflation"* before he stood for the Labour leadership (Callaghan 1987:287).

Such was the Labour government's conversion to a monetarist approach to the economy that around the same time as the IMF request the Prime Minister was arguing in the House of Commons that the Government would resist the temptation to *"lose their nerve"* on the money supply, unlike the previous Conservative government in 1972-3 (HC Deb:12 Oct 76 Col 235). According to Jenkins: *"Callaghan's*

¹⁹ The United Kingdom had taken a short-term \$5 billion loan from the International Monetary Fund for the period June-December 1976 to cover Sterling volatility.

three years as prime minister (1976-9) sowed the seeds, but only the seeds, of the dismantling of the post-war consensus"(Jenkins 2006:35).

Labour's adoption of monetarism was, however, born out of necessity rather than conviction. Professor Milton Friedman, in his acceptance speech for the Nobel prize for economics in December 1976 quoted Callaghan's conference speech and described this and a similar Canadian government statement as: *"remarkable statements, running as they do directly counter to the policies adopted by almost every Western government throughout the post-war period"*. They were, he said, driven by the *"force of events"* rather than ideology or political belief.(M. Friedman 1976)

The austerity programme imposed as a major component of the IMF agreement had an inevitable impact on the NHS. In 1978 the Social Services Secretary, David Ennals, told his Cabinet colleagues of rapidly rising waiting lists, untreated illness, dilapidated hospitals, and low morale, in support of his bid to win an agreement to raise annual health spending growth for the following two years to 3 per cent from the 1.7 per cent then planned(Cabinet 1978).

The New Right and the Conservatives

Britain's public spending problems had developed under both the Conservatives and Labour. As Bacon and Eltis noted: *"employment in education increased more rapidly when Mrs Thatcher was Secretary of State for Education and Science (1970-74) than in 1964-70; and during the same period, when Keith Joseph was Secretary of State for Social Services, employment in the provision of health and welfare services grew 8.2 per cent faster than employment in general"* (Bacon and Eltis 1976:14). Whilst the apparent ideology of the Conservatives had changed little from the 1970 manifesto, the strong resolve within much of the new leadership in 1975 to implement the free-market agenda in practice was completely new.

The term "New Right" had already come into common usage in the 1970s(Garnett 2010). The Fabian Society had already published a pamphlet on the topic in 1968(Collard 1968) and in 1969 Philips used the term in predicting a rightward shift in

American politics(Phillips), successfully encouraging Richard Nixon to resist the temptation to moderate his policies when faced with the US Presidential election. The New Right combined an emphasis on morality and traditional values with a critique of the increasing role of the state.

An early indication of the former was given in Keith Joseph's 1972 speech in which he put forward a hypothesis giving an important role for families in maintaining an unfortunate "cycle of deprivation" that had proven unresponsive to the growth in social spending since the war (Welshman 2005). Mrs Thatcher's instincts lay in the same direction. In her memoirs (dedicated to Joseph) she recalls her Methodist upbringing in Grantham: *"It was a visiting Congregationalist minister who brought home to me...that whatever the sins of the fathers (and mothers) they must never be visited on the children,"* although she balances this at the time of writing with the view that society may have gone too far in removing stigma from parents as well as children: *"We still have to find some way of combining Christian charity with sensible social policy".*(Thatcher 1995:11). According to Thatcher, whilst the economic *"left-of-centre"* consensus was being challenged in the late 1960s, the *"new liberal consensus on moral and social matters was not"*(Thatcher 1995:150). It was the combination of these elements in the 1970s that produced what has become known as the New Right in Britain. This was far more than economic liberalism, as noted by the economic journalist Samuel Brittan, in his epilogue to his 1987 update of his 1972 book *"Capitalism and the Permissive Society"*. Brittan refers to the 1980s approach taken by Reagan in the US and Thatcher in the UK as *"The New Spartanism"* with common features: (i) *a hawkish or super-patriotic attitude to foreign and military affairs;* (ii) *an opposition to social permissiveness and a desire to return to 'traditional values';* and (iii) *a hostility to government economic intervention, often partial and inconsistent, but going beyond that of previous Republican or Conservative governments. The first two features are the opposite of liberalism in the sense of a belief in freedom and emphasis on the individual rather than a group or nation.*"(Brittan 1988:240)

Alongside Joseph and Thatcher, Enoch Powell may have played a more significant frontline role in the emergence of the New Right had he not fallen from favour following an ill-judged speech on immigration in 1968. Nevertheless, he remained an

important influence on Thatcher and others thereafter, although Joseph became her principal mentor. In 1975 Thatcher's Shadow Defence Secretary, Ian Gilmour, told a journalist off the record that it was: *"Not clear who she listens to except Keith Joseph"* (Young and Trewin 2009:49).

Thatcher was also very open to the views of business leaders. John Hoskyns, the Chairman of the Hoskyns Group, was taken on by her in 1975 to lead the Conservatives' policy development in opposition, and later became the head of the 10 Downing Street Policy Unit when she became Prime Minister. Hoskyns' *"Stepping Stones"* report laid the basis for the Conservative government's strategy in its first term from 1979. Hoskyns convinced Thatcher that economic rectitude alone would not solve Britain's problems, but needed to be accompanied by a range of strategic "turn-around" measures for the long-term, including a transformation in the attitudes and role of the trades unions (Hoskyns 1978). Once in Government, however, Hoskyns soon tired of the limitations placed on the radical agenda and resigned as head of the Downing Street Policy Unit in 1981 (Jenkins 2006:82).

"The Right Approach"

As a former education and housing and local government minister Thatcher always showed limited interest in health policy in comparison to an ongoing focus on the aspects of policy for which she had been responsible under Heath. But in 1977 she explained her views on the NHS in an interview with the Sunday Times. In addition to her main theme of reducing NHS bureaucracy in order to save money:

"...she said she would like to see more people have the chance to provide for themselves independently, though it couldn't be done quickly. She agreed, however, that expensive independent education and health care provided an escape route only for a very few – until there was a much bigger income in the pay packet. That was why she supported mixed public-private features such as the Direct Grants schools (the Conservatives would bring them back), and amenity beds. She said she believed the health service would be in 'considerable financial difficulties very soon, and it would be better if we moved in a direction

which encouraged people to take out their own insurance'. Only a few could, but at least it brought more money into medicine as a whole" (Butt 1977).

In October 1976 the Conservatives had compiled a paper setting out their policies under their new leader, entitled "The Right Approach".. The section on health policy provided a clear statement of the intended direction:

"The Health Service is the largest single employer in the country and one of the biggest spenders. But the demands on the service have risen even faster than the increase in resources devoted to it. The advance in medical techniques, the rise in the number of elderly people in need of hospital attention, and what has been called the 'infinity of demand, for medical care have together put an immense strain on the service...

When the service is short of funds for priority tasks, there is no case for holding down prescription and other charges. More important, we should encourage rather than deter private provision. Increasing numbers of people have shown that they are ready to provide more for themselves; private medical insurance has doubled and redoubled over the last twenty years. It will be our aim to encourage this trend, and in particular to reverse the run-down in NHS pay beds. There is a strong argument for seeing that pay bed revenue goes directly to the hospital concerned, where it can be spent on identifiable items of equipment.

We see no reason for quantitative controls over the development of the private sector outside the NHS. We are examining ways of providing greater financial incentives to employer-employee medical insurance schemes, for example by restoring income-tax relief. The Royal Commission on the Health Service should be looking at other ways of increasing the funds available to the service, including systems of health finance that exist in other countries...
" (Conservative Party 1976:60)

The Conservative Campaign Guide 1978 supplement made much of the number of patients on waiting lists for hospital inpatient treatment, which had risen to over

600,000 under Labour and attacked Labour's reductions in NHS paybeds, arguing that insurance and the private sector had an important part to play in the financial sustainability of the NHS, alongside increased charges.(Conservative Party 1978:156)

The 1979 Conservative Manifesto, however, paid little attention to health policy. It was covered in a short section outlining one of their identified five tasks "Helping the Family":

HEALTH AND WELFARE

The welfare of the old, the sick, the handicapped and the deprived has also suffered under Labour. The lack of money to improve our social services and assist those in need can only be overcome by restoring the nation's prosperity. But some improvements can be made now by spending what we do have more sensibly.

In our National Health Service standards are falling; there is a crisis of morale; too often patients' needs do not come first. It is not our intention to reduce spending on the Health Service indeed, we intend to make better use of what resources are available. So we will simplify and decentralise the service and cut back bureaucracy.

When resources are so tightly stretched it is folly to turn good money away from the NHS and to discourage people from doing more for themselves. We shall therefore allow pay-beds to be provided where there is a demand for them; end Labour's vendetta against the private health sector; and restore tax relief on employer-employee medical insurance schemes. The Royal Commission on the Health Service is studying the financing of health care, and any examination of possible longer term changes - for example greater reliance for NHS funding on the insurance principle - must await their report.

In the community, we must do more to help people to help themselves, and families to look after their own. We must also encourage the voluntary

movement and self-help groups working in partnership with the statutory services. (Conservative Party 1979)

1979: The New Right in Government

Once in office the priorities for the new government were very clear. It had become essential to deal with Britain's economic problems, and to tackle the industrial unrest that was gripping much of the economy. The Government's challenges in 1979 extended much further than economic matters. These included Rhodesian independence, the overthrow of the Shah in Iran, and on-going terrorism associated with the troubles in Northern Ireland. Within the first two years in government the Conservatives also had to face a new peak of 3 million unemployed, and invasion of the Falkland Islands, and threats of another strike in the coal mines. On the latter, Mrs Thatcher was painfully aware of the factors that led to the fall of the previous Conservative government. When appointing a new Energy Secretary in September 1981 she told him categorically: *"we mustn't have a coal strike"*(Lawson 1992:140).

The Labour Party at the same time widened the ideological divide by electing a left-wing leader, Michael Foot, following the resignation of Callaghan. This, in turn, led to the defection in 1981 of the "Gang of Four" of leading Labour politicians to create the Social Democratic Party (SDP), which for its first few years became an electoral concern for both Labour and the Conservatives. By the end of 1981 combined electoral support for the Liberals and the SDP reached more than 50 per cent(Crewe and King 1995:133, Fig 1). In a by-election that year within the Labour stronghold of Warrington Roy Jenkins stood for the SDP and gained 42 per cent of the vote, to Labour's 48 per cent. Shortly afterwards the Conservatives lost Croyden North-West to the Liberals, then Shirley Williams took the "safe" Conservative seat of Crosby for the new SDP, and in March 1982 Roy Jenkins won the former Conservative seat of Glasgow Hillhead. During 1981, particularly after the Budget, Thatcher was warned of numerous potential defections to the SDP. In November the Conservative Research Department produced an analysis of the situation saying: *"This new phenomenon [the Alliance] may well end by burying the old Labour party, but the electoral and poll evidence suggests that it threatens also to sweep the Conservative party into a small minority*

position, worse than anything we have experienced for over one hundred years".(CRD 1981) But from this point onwards the environment improved for the Conservatives, and the SDP threat to them declined(Crewe and King 1995:136-147).

The new government of 1979 had been determined to mix the immediate economic needs of the country with ideologically-driven steps in other policy areas. Thus the first legislative agenda included the abolition of price controls and the creation of an Assisted Places Scheme, to support children with bursaries for private education(Thatcher 1993:39), alongside school choice within the state sector. Whilst the new Chief Secretary to the Treasury, John Biffen, was willing to spend an additional £50 million above Labour's pre-election spending plans in order to fund the Assisted Places Scheme, he expected the NHS to produce £100 million of annual savings within two years by means of increased prescription charges, the reversal of Labour's removal of pay beds, and the abolition of Area Health Authorities (Cabinet 1979:3). In the Housing Act (1980) the Government introduced "right-to-buy" legislation which allowed tenants in social housing to buy the local-authority properties in which they lived at a discount.

By 1981 the Chancellor of the Exchequer was well aware of the political risks of putting additional financial pressure on the NHS, warning the Cabinet that they would need to look for new ways to cut public sector borrowing, including areas previously considered "sacrosanct" in order to make tax cuts and measures to tackle unemployment possible. Unemployment was already forecast to rise soon afterwards to a post-war record of more than 3 million. According to the Cabinet minute the Government was running the risk of going into the subsequent election with the overall burden of taxation higher than the position in 1979 when the Conservatives came to power, with both unemployment, and inflation risen. But, despite this political imperative, they could also ill afford deterioration in the NHS: *"Some programmes had already been cut to such an extent that to look for further cuts was politically unrealistic. Measured as a percentage of Gross Domestic Product the health and social services programmes in the United Kingdom were significantly smaller than in all other member countries of the European Community"*.(Cabinet 1981).

Industrial relations problems were as evident in the National Health Service as elsewhere in the public sector, as pay restraint remained at that time a key component of the battle against inflation, as the Conservatives had not yet adopted a completely monetarist approach to inflation(Lawson 1992:47-48). Amidst the public sector austerity the Conservatives in their first term also faced the prospect of two reports commissioned by its predecessor which were likely to increase the pressure for spending. The Royal Commission on the NHS was set up in 1975 by Barbara Castle, as a means to put Labour's serious problems with the NHS to the side for a while. The junior doctors were in dispute with the government, and the BMA was asking for an independent inquiry, although they (and the Prime Minister) wanted the issue of pay beds included, which Castle resisted(Castle 1990:662-664). The health minister, David Owen, said of the Royal Commission that he: "*juggled its membership to ensure that it was at least composed of sympathisers, not antagonists to its principles*"(Owen 1991:237) and Castle made it clear to the chairman, Alexander Merrison, when appointing him that the issue of pay beds was not to be included. Merrison was, anyway, she claimed: "*the product of a left-wing family, and instinctively against pay beds*"(Castle 1990:711) and his name had come up because ministers viewed him as: "*a dedicated supporter of the NHS...[who] would have no truck with private financing and all that nonsense*" (Castle 1990:671). The creation of the Royal Commission did not, in fact, lessen the Government's problems with the NHS in general, or the junior doctors in particular but, given its carefully chosen membership, it did present a serious trap for an incoming Conservative government.

Another potential trap was inadvertently set by Castle's successor at the DHSS, David Ennals, who replaced her once James Callaghan had succeeded Harold Wilson as Prime Minister in 1976. It is reported that Ennals was persuaded by Brian Abel-Smith(Berridge 2002:133) and Douglas Black to launch an investigation into health inequalities, which Ennals thought might provide a good basis for a celebration for the 30th anniversary of the NHS in 1978. But, as Black himself, has reflected: "*It took us three years to disappoint him*" (ibid). Unlike Castle's Royal Commission, the Black Report was not an attempt to defuse or delay debate on a difficult subject, but Black was determined that he would not be pressurised by time, regardless of either Ennals'

wish for a 30th anniversary celebration or the prospect of a change of government(Berridge 2002:141). It was thus Patrick Jenkin, Mrs Thatcher's first Secretary of State at the DHSS, who received Black's report in May 1980, which proposed measures "*costing upwards of £2 billion*". Publication of the report was held back until the summer recess, after contentious social security upratings had been agreed in Parliament, but publication during the summer holiday added to the political difficulty caused because it gave every impression of suppression (Jenkin 2002).

Patrick Jenkin had worked over the Conservatives' final three years in opposition in the 1970s with a group of advisers devising a publicly-administered health insurance system, only to be thwarted in his ambitions by Department of Health civil servants once he gained office.(Timmins 2008:33). The Institute of Economic Affairs (IEA), which became an important influence over Conservative Party policy in the 1980s, had also been working for some time on alternative systems for raising and distributing health funding. It became particularly associated with the promotion of the replacement of the state provision of education and welfare services with voucher schemes (Arthur Seldon 1986).

McLachlan describes how the 1979 election had marked the apparent end of a cross-party consensus in support of the NHS, amidst increasing interest in alternative models of health funding and provision (A Culyer et al. 1982:6). He also noted open ministerial interest in continental European social insurance systems, albeit alongside a formal policy that was limited to encouraging the growth of a complementary private health insurance system(A Culyer et al. 1982:8-10), and a Bill to this effect was announced in the new Government's first Queen's Speech in May 1979. Nonetheless, there was no significant change as a result of this activity.

According to Willetts, a conservative policy adviser in the 1980s: "*The Government's policy in its early years was so cautious that it is no surprise that some people concluded there must be a more radical secret agenda*" (Willetts 1989:45). Indeed, the strong NHS manifesto commitments of the Conservative governments elected in 1970 and 1979 invited suggestions of a secret agenda given the contrast with their over-riding ambitions to reduce the role of the state and promote individual enterprise and

responsibility. Hence the widespread media interest in early leaks of any Whitehall interest in alternative funding systems. Additionally, the appointment of Gerard Vaughan as health minister in 1979, meant that the NHS found itself under the leadership of a politician who, as a hospital consultant, understood his brief and who was *"not an enthusiast for the Bevanite model of a National Health Service"* (Independent, 21 May 2009).

Early on health ministers did commission officials to establish a working party to look at alternative funding systems. The working party had wide participation from across government, including the Central Policy Review Staff (CPRS). It also included two external consultants who, the minister said, had *"many years' experience in health care outside the NHS"* (HC Deb 10 November 1981 c 77-9W). Additionally two health officials were given a travelling fellowship to study European and North American health systems (ibid.).

Walter Holland recalls this Departmental exercise: *Mrs Firth and Jeremy Hurst were sent off to look at private insurance cover. There was a lot of discussion as to whether in fact the whole system should change to a social insurance system or whether you could change to a private insurance system".* They later presented their findings at a confidential seminar held at the Civil Service Staff College, with around 20 participants drawn from the civil service, the medical profession, academic medicine, the British Medical Association, and the health insurance sector, but no politicians. *"There was a very clear division of opinion"* says Holland: *"All the doctors except the BUPA man, were absolutely united in opposing any change to an insurance system"*. In the open session the representatives of the insurance industry *"chose their words very carefully"*, but in private discussion they *"were absolutely explicit they wanted no part."*²⁰

The review of 1981 held out no prospect for an alternative system being any cheaper than the NHS, so that the project progressed no further in 1982. Some of the ideas on privatisation options for dental and ophthalmic services, and a move to activity-based

²⁰ Interview: 26 May 2009

funding for hospitals did however, later take place although this had little to do with the study.(Smee 2005:32).

Other events in 1982 did have an important effect on Conservative handling of the NHS and its future. The Treasury was concerned that the government should develop a view on the prospects for public spending into the 1990s, and in February 1982 the Chancellor, Geoffrey Howe, obtained the Prime Minister's agreement that the Treasury, the Central Policy Review Staff²¹ (CPRS), and the spending departments should work to produce this. Due to the Falklands War the work did not begin until the summer, with Howe telling the Prime Minister that: "*Radical changes affecting most if not all major programmes will be required*", and a special Cabinet meeting was held on 9th September 1982. Howe recalls that: "*The one serious mistake which I made was to propose that the CPRS should also be asked to 'point up some possible long-term options'. Or, more accurately, I had erred in allowing the CPRS to become involved on such a tight time-scale, for we had left insufficient time for any resulting CPRS paper to be edited or revised*" (Howe 1994:257). At that time the CPRS had a new and politically inexperienced head recruited from a merchant bank.

According to Howe: "*The CPRS paper amounted to a rather alarming schedule of very radical policy ideas many of which had been rejected several times already...The meeting was a disaster*" (Howe 1994:258). Lawson has described the meeting as "*the nearest thing to a Cabinet riot in the history of the Thatcher administration*" (Lawson 1992:303). Thatcher herself recalls: "*I was horrified by this paper. As soon as I saw it, I pointed out that it would almost certainly be leaked and give a totally false impression*", adding that "*We were to be plagued by talk of secret proposals and hidden manifestos up to polling day and beyond*". (Thatcher 1993:277).

The Health and Social Services Secretary, Norman Fowler, has also described the September 1982 CPRS paper as "*disastrous*" given that he was engulfed in industrial unrest in the NHS at the time (Fowler 1991:183-5). The document and Cabinet discussion leaked within days. The Economist magazine reported that:

²¹ The CPRS was created within the Cabinet Office in 1971 by Edward Heath. Tessa Blackstone and William Plowden, *Inside the Think Tank : Advising the Cabinet 1971-1983* (London: Heinemann, 1988):10

The paper suggests replacing the National Health Service with private health insurance...In the meantime savings could be made by charging for visits to the doctor and more for drugs" (Economist 1982, 18 Sept).

Amidst the political furore surrounding the CPRS paper both Fowler and Thatcher had to use the Party Conference the following month to re-state their firm commitment to the NHS (Fowler 1991:187). The Department of Health's chief economist has noted that the leaking of the CPRS report: *"effectively stopped all work on radical funding alternatives for six years" (Smee 2005:32)*. Mrs Thatcher abolished the CPRS immediately after the 1983 election, and in the years that followed it appeared that she had indeed determined that NHS privatisation was a political battle in which she would never engage. Social policy was, anyway, not at the heart of political debate around the time of the 1983 General Election which, as Raison recalls, *"was about the economy, nuclear weapons, Europe and leadership, and took place against the backdrop of the Falklands"*.(Raison 1990:122)

Pearson described the NHS as: *"The one 'untouchable' which has thwarted the Thatcher government's mission to roll back the frontiers of the state" (Clope 1992)*. The lack of a viable alternative model, however, meant that the only recourse was to strict budgetary control and the pursuit of efficiency. Shortly after the 1983 General Election the Leader of the House, John Biffen, confided to a journalist that Lawson, who was now Chancellor the Exchequer, wanted ongoing spending cuts, in order to fund tax cuts. *"The Tory party likes its cottage hospitals" he said(Young and Trewin 2009:193)*.

The widespread industrial unrest experienced by the NHS and union demands for flat-rate increases, alongside fears of a growing NHS bureaucracy, led to a shift of the policy focus onto strengthening the management function, particularly personnel management, within the NHS.(Edwards and Fall 2005:14). The imposition of a 4 percent public sector pay factor, intended to establish a norm for pay rises, led to widespread industrial unrest in the NHS involving 13 unions, that lasted eight months(Rivett 1998:352), and resulted in the Secretary of State requiring a police guard(Fowler 1991:172). The coincidental leaking of the CPRS Report added to a

general sense of crisis in the NHS. The dispute finally ended in December 1982, with the establishment of an independent pay review body for the nurses (as already existed for doctors) and a two-year agreement with the other public sector unions. Against this background Fowler announced the creation of the Griffiths Inquiry in the search for a longer term solution.

In appointing Roy Griffiths, the Managing Director of the Sainsburys supermarket chain, Thatcher once again turned to a businessman for advice. Griffiths insisted, against the wishes of Thatcher and Fowler, that the inquiry should cover the whole of NHS management and not just manpower (Graham 1994)²². This insight demonstrates that in 1982 the political focus was on tackling the industrial relations problems of the NHS, and not on a wider agenda for fundamental change. The Griffiths Report was short and precise, setting out a clear prescription for managing the NHS.

In a review of NHS changes since 1983 the publication of the Griffiths Report has been described as a "*seminal moment for the NHS*" which "*arguably provided a turning-point at which NHS management was transformed. Indeed, without 'Griffiths' it is fair to surmise that NHS management would not look or act like it does today.*" (Macfarlane 2012:135). Griffiths appears to have brought into the health service the new business-like approaches that were already permeating most other aspects of public administration (Gorsky 2010:23). Indeed, Graham Hart, a former Permanent Secretary at the Department of Health has described how "managing" the NHS was simply not part of the role of the Department of Health before the Griffiths Report, as responsibility rested with the health authorities (Gorsky 2010:26). The case for management systems within the NHS was reinforced by the official inquiry into a 1984 outbreak of food poisoning in an NHS hospital that killed 19 patients. The Report found evidence that health authorities had no plans for such major events, and confused lines of accountability (DHSS 1986a)

²² Fowler has recently denied that a manpower inquiry was originally intended despite the strong evidence to the contrary Martin Gorsky, 'The Griffiths Nhs Management Inquiry: Its Origins, Nature and Impact', *Witness Seminar 11 November 2008* (London: London School of Hygiene and Tropical Medicine, 2010):14-15

Day and Klein highlight some of the environmental factors driving change in health policy, not least the rise in consumerist attitudes, reflected in strong growth in private medicine and rising legal claims over NHS treatment, and rising expectations. Whilst the population might have previously accepted NHS mistakes as par for the course, this attitude was clearly changing, and negligence claims were increasing from a very low base throughout the 1980s. The average subscription for medical defence rose ten-fold between 1980 and 1988 (Day and Klein 1989:13). These cultural changes would serve to increase demands on the NHS, together with the effects of an ageing population. The problem of affordability could only worsen.

In the 1970s Barbara Castle had argued that the NHS required real-terms annual funding increases of one-per cent above the retail prices index in order to maintain service levels whilst faced with an ageing population, plus a further one-per cent in order to keep pace with advances in medical technology (Rivett 1998:356). A decade later Nick Bosanquet, from the Centre for Health Economics at York, produced a report on NHS funding for the British Medical Association, the Royal College of Nursing, and the Institute of Health Services Management. Bosanquet's analysis demonstrated that a minimum real increase for hospital and community health services was needed of at least two-per cent per annum, and that a commitment should be given to such a sustained increase over three years, alongside full-funding of Pay Review Body awards (Nicholas Bosanquet 1985a). The three organisations met with the health minister, Barney Hayhoe, to present the research. Whilst the minister agreed with the calculation that two per cent growth was required, he asserted that this implied growth in services, rather than growth in funding (Hayhoe 1986)²³. The Department of Health responded more fully with a firm assertion that it believed that there was still "*fat to cut*" from the NHS, and that efficiencies due to the introduction of general management and other measures would be "*substantial*" (DHSS 1986c).

Even before the 1987 election the Prime Minister was becoming frustrated that the extra funding and managerial reforms of the NHS had not dealt with the problem of

²³ Total real terms health spending growth swung from 0.2 percent in 1985-6 to more than four percent in each of the three years that followed, before falling to 0.7 percent in 1989-90 (HC Debates 16 February 1998 c492W)

NHS waiting lists, suggesting that if GPs and patients could not make informed choices between hospitals there would be little pressure for improvement.(Edwards and Fall 2005:56). Early in 1987, therefore, DHSS officials prepared another report for the Prime Minister *"Towards Better Healthcare: A Case for Change"* again outlining possible insurance schemes, additional charges and tax incentives for the take-up of private medical insurance. (Edwards and Fall 2005:56). The paper also commented on Professor Enthoven's suggestions for an internal market system within the NHS(Enthoven 1985), although Downing Street felt that an internal market would be unlikely to *"give sufficient voice to the consumer"*. (Edwards and Fall 2005:57), which was to be a central theme of the 1987 election manifesto.

To some commentators, however, the "management agenda" in health policy appeared far from cautious. Ham, for example, has argued that this agenda brought: *"to an end the period of incremental adaptation that had been characteristic of the post-war consensus on the NHS"*.(Ham 2000) This, however, was already not the first time that such a breach of consensus had been claimed. Nor would it be the last. It was clear, however, that whilst there were problems aplenty, there also seemed to be more substantive reform ideas beginning to appear in what Kingdon (1995) refers to as the "policy primeval soup".

6. An Internal Market

This chapter and the case studies that follow explore the major health policy changes that took place under the Conservatives, set against the history of the Conservative approach that has already been discussed. As set out in the conceptual framework for this research it is important to consider the possibility that the changes that were witnessed in the 1980s and 1990s might have roots that form part of a Conservative approach to health policy that predates the creation of the NHS. It may, of course, also be the case that change is sometimes a spontaneous reaction to short-term events, but setting events in their historical and cultural context should assist in making these distinctions. Having traced the development of Conservative Party thinking the research now seeks to set out the main characteristics of the political environment and to map relevant developments leading to each policy using three streams of problems, people, and policies. As a study of policymaking amongst the policy elite the research is focused on the people involved, whilst incorporating the remainder of Kingdon's "politics" stream into the discussion of context.

Background

The internal market reforms received extensive coverage at the time of their development in 1988-89 and introduction in 1990 and the years that followed. The Labour Party committed itself to abolish the new system, which was a commitment that it only partially fulfilled when next elected in 1997. All of this has been thoroughly documented (Timmins 2001:431-492) and analysed (Le Grand et al. 1998).

My intention in this chapter is to understand how the particular set of reforms that emerged came about, and the factors that generated such change. The internal market reforms, as the name suggests, were ostensibly intended as a means of improving the internal operation of the NHS, and not with shifting the boundaries in either the finance or provision of care. They may, nevertheless, have facilitated subsequent boundary shifts due to their impact on the health policy environment. The focus of the analysis here is to unearth data that sheds light on the motivations,

intentions, and tactics of those involved rather than to present another history of this short but fascinating period of British politics.

At some point the NHS did take a decisive change of direction in terms of the provision of care, developing a mixed market in the supply of care similar to those which have been seen in many other aspect of welfare provision with increasing recourse to independent provision (Glennister and Le Grand 1994) In 2010 the new Conservative-Liberal Democrat coalition government announced proposals to "liberate" the NHS, and quickly produced a substantial Health & Social Care Bill to enact the changes. These included entrenching the principle that the NHS should commission "*any willing provider*" to provide NHS-funded care, rather than rely mainly on NHS providers. At this point some of those who supported the internal market in the 1980s expressed the view that an external market had, in fact, emerged.

In 1986 Dr David Owen, Leader of the Social Democratic Party (then in a formal alliance with the Liberal Party) lent his party's support to Alain Enthoven's suggestions of an internal market for the NHS(Enthoven 1985). Owen argued that: "*An internal market could serve patients' interests better than the present model*" adding that as well as a market between district health authorities "*the internal market would, as today, enable authorities to buy services from the private sector and vice versa. To win acceptance for the internal market model it will be necessary to convince staff and, particularly, the health unions that this is a sensible development, wholly within the ethical principles of an NHS whose remit is to provide care on the basis of need, not the capacity to pay*"(Owen 1986:170-71).

In July 1987 Owen recommended an internal market to the Government, adding that its introduction would also be: "*a good opportunity to deal with the frontier between the private and public health sectors. It makes no sense to prevent somebody who can be dealt with in a private hospital more cheaply than in another part of the NHS from having treatment. There is no reason why treatment cannot be contracted out if a patient can have his inguinal hernia dealt with in that way. Good for him. He does not pay—the health district pays*" (HC Deb 2 Jul 1987 Col. 663). Owen did, however, see the private sector as a supplier to the NHS and not a "competitor", arguing that

Conservative policies to actively promote the private sector risked damaging both the NHS and social cohesion within the country (Owen 1986:171).

Twenty-five years later, however, when confronted with a Health and Social Care Bill that actively promoted competition in healthcare Owen expressed his regret that: *"at the very early stages in 1985, I was the advocate of the internal market. I must say I am ashamed of that advocacy now. So often the work that was done on an internal market is used to justify the external market that is the basic fundamental underpinning of this Bill, which I am afraid will become an Act"*. (HL Deb 25 oct 2011 Col 674). It seems that Owen had assumed in 1985 that his proposed reforms would provide a final solution for the NHS, and not form part of a progression to a market-based environment for health care.

This episode, which took place over a quarter century, serves to emphasise the value of policy analysis that sets specific events within their historic context. The Conservatives went into the 1987 General Election with a manifesto focused on rising prosperity, tax cuts, and a consumerist approach to housing and education. The manifesto said that local authority housing tenants would be given rights to opt-out of local authority control of their estates, and parents would be given more effective choices between schools, compared to the 1980 Act that already provided a degree of choice, and schools would be able to manage their own budgets. Polytechnics too would be taken out of local authority control, with their own budgets.

In what has since been described as *"the most unpopular decision Thatcher made...which played an important part in her downfall"* (Anthony Seldon and Collings 2000:111) the Conservative Party committed itself to a high profile policy to quickly replace local rates with a "community charge". With regard to the NHS the Conservative manifesto was, according to Thatcher herself *"notably cautious"*(Thatcher 1993:577) and sought only to offer reassurance of an on-going commitment on funding, capital investment, public health, and managerial flexibility. It offered no suggestion at all of major changes ahead.(Conservative Party 1987b)

Problems

Health and the 1987 General Election

The Conservatives went into the 1987 election with a strong case to present to the electorate; unemployment was falling, the public sector deficit was on track to be eliminated entirely, and the Chancellor had produced a populist Budget with a substantial cut in income tax(Young 1990:512). These were the grounds on which the Conservatives would campaign. They may have chosen to fight the election on grounds other than health policy, but the opposition parties made this a central area of attack. Thatcher knew that this would be the case as health was a particular "*weak point*".(Thatcher 1993:577)

Both the Labour Party and the combined SDP-Liberal Alliance targeted the Conservatives' perceived vulnerability in this area. But it was a journalist who was to use health policy to cause problems for the Conservatives in the final week of their re-election campaign. According to the then health minister, the question at a daily press conference was just an oft-repeated "*try on*", asking why the Prime Minister used private health facilities rather than the NHS; but Thatcher was suffering from a painful tooth abscess which had kept her awake overnight, and was irritated by a sudden and unexpected Conservative slide in the opinion polls(Thatcher 1993:584), and her "*patience snapped*" and she gave a long and damaging reply(Fowler 1991:279):

"I, along with something like 5 million other people, insure to enable me to go into hospital on the day I want; at the time I want, and with a doctor I want. For me, that is absolutely vital. I do that along with 5 million others. Like most people, I pay my dues to the National Health Service; I do not add to the queue, and if I said, 'Look, because I cannot come when you want me, I must come when I want to', you would accuse me of jumping the queue. 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. (Conservative Party 1987a)

NHS finances

The debate over NHS funding intensified from 1985. The aspirations for management efficiencies following the Griffiths Report (Griffiths 1983) meant that the Conservatives expected savings to produce much of the two-percent annual growth called for by independent research (Nick Bosanquet 1985b; Maynard and Bosanquet 1986). According to Timmins, the Department of Health and Social Security had been routinely "*getting just enough cash to survive*", and before the 1987 election the NHS had been building up debts, including delayed pay increases, so that it was technically bankrupt by the end of the election (Timmins 2001:452). For the Conservatives, however, by the time of the 1987 General Election they appeared to have succeeded in restraining health spending growth, having since 1982 consistently kept real growth in NHS purchasing power below 1 percent per annum (Owens and Glennerster 1990). During the second Thatcher term the seeds had been sown for the financial crisis that was to engulf the NHS in the winter of 1987-88.

Facing the prospect of another five years of Conservative government austerity for the NHS from 1987 two reputable and independent health organisations, the Institute of Health Services Management and the Kings Fund announced reviews of NHS funding in a search for alternative income sources. Additionally, John Moore, the new Secretary of State for Health and Social Security, went into routine spending negotiations with the Chief Secretary to the Treasury (John Major) and "*quixotically ... bid for too little money*", true to his philosophy as a former Treasury minister (Major 1999:105). The health minister Edwina Currie's diary records that John Major:

"gave me to understand [Moore] could have had more money in the recent PES²⁴ round if he'd boxed cleverer"²⁵. The NHS fell into financial crisis.

Even before the winter of 1987-88 health authorities began to close beds as an economy measure and industrial unrest over pay returned (Rivett 1998:358). The mounting financial problems of the NHS coincided with a devastating storm in southern England on Thursday 15th October 1987, and on the following Monday the year's transatlantic stock market boom came to a dramatic end on "Black Monday" and predictions of an economic slump (Lawson 1992:746). Even the medical Royal Colleges were attacking the Government, issuing a joint press release in early December 1987 calling for: "*an immediate overall review of acute hospital services*" and "*additional and alternative funding*" (Edwards and Fall 2005:63; Hoffenberg 1987). Later that month the Treasury finally conceded that the health minister's demands for extra funding were essential and provided an additional £100m.

The problems of the NHS had been personified in November 1987 by the case of David Barber, a "hole in the heart" baby, due for treatment at Birmingham Children's Hospital but whose operation was cancelled five times in six weeks, due to a shortage of specialist nurses. His parents had taken unsuccessful legal action in an attempt to force the hospital to operate. He was finally treated in late November, but died (Edwards and Fall 2005:63; ITN 1987). A stream of other paediatric cardiac cases followed throughout the winter. (HC Deb 15 January 1988 cc645-52). According to Lightfoot, a Treasury political adviser this was: "*one of those periodic moments when [the NHS] blew up as a media thing, provoked by some genuine underlying problems*"²⁶.

At this crucial and difficult time the Secretary of State at the DHSS had been absent, from mid-November to mid-January, suffering from pneumonia, and it was left to the Minister for Health to launch a White Paper on Primary Care which, as an

²⁴ Public Expenditure Survey – The annual negotiations between spending departments of Government and the Treasury

²⁵ Unpublished diary entry: See Annexe

²⁶ Interview 27 July 2011

economy measure worth £170m, included the removal of free sight tests and additional dental changes (HC Deb 25 November 1987 cc259-60).

Announcing a Ministerial Review of the NHS

The session of Questions to the Prime Minister (PMQs) on 21st January 1988 was almost entirely taken up with questions about the NHS "crisis". (HC Deb 21 January 1988 cc1090-4). Within a week, and before she next faced PMQs she had announced a ministerial review of the NHS. Moore had urged her to launch a review when he was appointed to the DHSS in June 1987, and in January 1988 it seems that both the Chancellor, Lawson, and her Official Spokesman, Ingham, had both recommended that the time had come for a review. (Lawson 1992:614). According to Libby the Prime Minister "used it to get out of a hole on *Panorama*"²⁷. Lawson believed that: *"The start of a new Parliament was the only practical time to consider the matter"* and the Health Minister, Fowler, has commented that: *"There would never be a better time to introduce legislation which would inevitably face hard battles in both Houses of Parliament. It was now or never."* (Fowler 2008:26)

The Permanent Secretary at the DHSS believes that it was the high-profile tactics of the medical professions over the winter of 1987-88 that finally convinced the Prime Minister of the need for a thorough review of the NHS rather than simply continue to provide more cash although they were, of course, hoping for the latter (Edwards and Fall 2005:65).

Thus, on 25th January 1988 the Prime Minister announced a review during a BBC "Panorama" television interview during which the interviewer, David Dimbleby, had accused her of *"dithering"* on the NHS and pressed her to consider the inevitability of a greater role for private care (McQueen Undated). The five-minister Review team

²⁷ Interview 3 June 2009

was established within three days, under the chairmanship of the Prime Minister(Lawson 1992:614).

In fact, even before the 1987 General Election, the Prime Minister had asked David Willetts, who had left her Policy Unit to join the Centre for Policy Studies (CPS) think tank, to undertake an unofficial review of the NHS, which she thought would have far greater freedom than an official review(Isom and Kandiah 2002:30). Willetts believes that in making her *Panorama* announcement she was, in fact, referring to the CPS Review (Timmins 2001; Willetts 2006:457-8) but that immediately after making the review public she realised that a degree of control would now be needed. Willetts has also suggested that Thatcher had earlier hoped that the economist Lord (John) Vaizey would lead such an external review (Isom and Kandiah 2002:30); but Vaizey died in 1984. This does suggest that she had long intended to turn her attention to long-term reform of the health service.

The experience of the election itself had perhaps moved Thatcher towards a fundamental review. Claims of a secret Conservative agenda had plagued the Party at both elections since the leaking of the 1982 CPRS report. According to Willetts, who was assisting her during the 1987 election campaign, being accused of having a secret agenda when there none existed "*was the worst of all possible worlds... far better to have a genuine reform agenda which would be out in the open*", but it was the addition of a financial crisis from the Autumn of 1987 that finally convinced the Prime Minister.²⁸

The then Chairman of the British Medical Association described the *Panorama* announcement as a "*classical political device to divert attention from the NHS scandal*" (Marks 2008:168) But, even as an official review, this was not to be another Royal Commission lasting several years, but something more similar to the Griffiths review of NHS management, to produce answers for implementation before the next election. In fact, the Prime Minister had already given considerable thought to radical NHS funding and structural reform immediately before the 1987 election,

²⁸ Interview 4 July 2006

commissioning a secret report from the Department of Health entitled "*Towards a Better Healthcare: A Case for Change*"(Edwards and Fall 2005:56).

Policies

When the Prime Minister announced the review in January 1988 the "policy privemal soup" did not contain a ready-made solution, and according to the Secretary of State for Health's political adviser: "People were invited from everywhere to send submissions in, which arrived in great volumes ... I think most of it was absolutely irrelevant"²⁹. David Green from the Institute of Economic Affairs (IEA), and others in the policy arena, was given a security pass so that he could spend time in the Department questioning officials and offering ideas. Green recalls: "I used to go over to John Moore's office in the afternoons when he was in the House of Commons and could ask civil servants to tell me anything. I wasn't allowed to take anything out, but I could take notes. Freestanding hospitals was discussed...but at that time I didn't ever get the feeling that it was going anywhere. It was little position papers... I would leave him little notes"³⁰.

Although there was no specific proposal available in January 1988, in health as in other policy areas there had been increasing interest in the use of market mechanisms to deliver social policy. Ideas to develop an internal market within the NHS, as mentioned earlier, and interest in decentralising the purchasing of care to GPs as a form of consumer empowerment had been discussed during the previous five years. Taking this a stage further, there was considerable interest in the use of earmarked vouchers to enable individuals to select services themselves, although these ideas failed to enter health policy making save for the introduction of spectacle vouchers which will be discussed later, and through the Assisted Places Scheme³¹ in education. The deadweight cost for the exchequer of any voucher scheme (funding those who would have paid for private care regardless) was always a major barrier to implementation of vouchers schemes for the Conservatives(Thatcher 1993:591).

²⁹ Interview 3 June 2009

³⁰ Interview 28 June 2011

³¹ The Assisted Places Scheme, introduced in 1980 provided means-tested bursaries for children to attend selective private schools.

They had, however, always carried considerable attraction for the New Right, particularly the IEA which had long promoted their use as a means for reducing the role of the state in service provision and empowering individuals, notably in education (M. Friedman 1962; L. A. Friedman et al. 1974; Jencks 1972; Arthur Seldon 1986) although the types of schemes vary, particularly according to whether the purpose is purely consumer empowerment as in the Friedman scheme which suggests vouchers of equal value that could be topped up, or also has equity goals, as in the Jencks scheme that proposes an inverse relationship between voucher value and financial means (Barr 1987:352; Nicholas Bosanquet 1983).

The "social market" and "market socialism"

As the 1980s progressed the shift towards market-based policies began to gain interest across the mainstream political and policy spectrum. The concepts of "social markets" and "market socialism" became popular areas for investigation. The social market drew on Germany's post-war success in combining economic discipline with well-developed social programmes with no bias towards state provision of services, whilst market socialism was more focused on the use of markets in the delivery of public services. The term "social market" was first adopted for the New Right in British politics by Keith Joseph in the 1970s. In doing so he was drawing on the liberal "Freiburg school" that had advised the Adenauer government on the post-war reconstruction of West Germany: including Walter Eucken, Wilhelm Röpke, and Ludwig Erhard, all of whom were closely associated with Hayek (Cockett 1994:109-110). Their philosophy, rooted in "sound money" was a response to Germany's earlier experience with hyper-inflation.

In 1981, shortly after the creation of the left-of-centre Social Democratic Party (SDP), one of its founders David Owen declared that the social market, which had been adopted by the New Right, was "*worth re-examining*" (Owen 1981:5). In 1989 as the SDP dwindled as a political party, Owen and his supporters established the Social Market Foundation think tank to continue to promote the use of market mechanisms as a social tool.

During the 1980s "market socialism" was also being developed to "*show that market mechanisms can be used to achieve socialist ends*", separating ends and the means by which they are achieved (Le Grand and Estrin 1989:1). Le Grand argued that:

"Market-oriented reforms of welfare provision, such as voucher and user taxes, particularly if coupled with systems of wealth taxes and poll grants, could make welfare in particular, and the wider society in general, more responsive, more efficient, and more egalitarian" (ibid:211)

Amongst Conservatives Willetts has argued that the use of markets within tax-funded welfare services, known as "quasi-markets", formed a core element of the Conservative's social policy agenda throughout the 1980s, and that the NHS reforms at the end of the decade fit within this agenda (Isom and Kandiah 2002:36).

General Practitioner Fundholding

Alongside the development of ideas around the separation of purchasers and providers to form quasi-markets, within the health policy arena ideas were also developing in the 1980s around the concept of General Practitioners holding budgets and acting as purchasers of services for their registered patients. The economist Lord Vaizey, a former Labour peer who joined the Conservatives in 1979, hosted a seminar at Cumberland Lodge (of which he was Principal) in June 1984. to discuss NHS reform ideas. Teeling-Smith recalled that Vaizey, who died shortly after the seminar, believed that: "*the principles of the Beveridge Report need to be fundamentally re-appraised in the light of the changes in British society since the 1940s.*"(Teeling-Smith 1984:3).

At the seminar Marshall Marinker³² presented a paper on his suggestions for radical changes to the NHS. In a shift away from a hospital-based NHS he proposed that private general practices might compete with NHS providers, to provide a system of "diverse and competitive primary care" including NHS franchised primary care units

³² Former Professor of General Practice, University of Leicester, and Director of the MSD Foundation 1982-92

which would be given annual budgets, so that *“the unit will become the budget holder”* (Teeling-Smith 1984:21) . Marinker draws on a suggestion from Maynard that these budgets could cover both primary and secondary care which would *“permit an entrepreneurial competitiveness in both...”* (Teeling-Smith 1984:22). The idea of GPs holding budgets, rather than health authorities had already been developed within government in 1984 in drafts for a Primary Care Green Paper. This was described by insiders as "the lunatic chapter" (Isom and Kandiah 2002:31) which was removed from the draft (Giaino 2002) before publication of the final paper although the final document did retain an emphasis on consumer choice (DHSS 1986b).

Other participants in the 1984 OHE seminar, who were actively working on similar themes to Marinker and who would play important policy roles in the years that followed included Alan Maynard, Director of the newly-established Centre for Health Economics at York University, Nick Bosanquet from City University, and Robert Maxwell from the Kings Fund. Marinker recalls that Bosanquet and Maynard thought his proposals for GPs holding budgets for all primary care needs *“timid”*, and suggested an extension to incorporate some non-emergency secondary care (Isom and Kandiah 2002:31). The seminar was also attended by the Government’s Chief Medical Officer, Donald Acheson, thus ensuring a direct link into the Department of Health.

These discussions coincided with rising interest within the USA on "managed care" delivered through Health Maintenance Organisations (HMOs)³³ acting as purchasers of Medicaid-funded care on behalf of their enrolled patients, but using prepaid plans rather than traditional insurance. Such a plan had been introduced in 1983 in Arizona, and had delivered improvements in the quality of care whilst achieving lower cost inflation than the traditional Medicaid programme, because the presence of an HMO as a selective purchaser within the market was generating stronger incentives for price competition amongst suppliers than had the insurance-based system. (Osborne and Gaebler 1993:87).

³³ These had existed on a small scale since the 1930s, when the Kaiser Company set up a health plan for its employees

In England in the early 1980s a HMO-style development in Harrow came to policymakers' attention. Dr Mike Goldsmith, a GP trainer, had earlier resigned from the NHS and established a private health centre funded by monthly subscription, similar to a squash club, rather than insurance; thus "free" at the point of use. Goldsmith says: *"I decided to do a different type of primary care, one that wasn't so poor quality [as the NHS] and one where it was a one-stop shop"* with in-house pharmacy and cardiac testing. The Harrow Health Care Centre aroused the interest of the Conservative Medical Society, David Willetts (then at the Treasury), John Redwood at the Downing Street Policy Unit, and the health minister Kenneth Clarke. Writing in October 1985 Laing highlighted the Harrow model as an example for: "the development of GP-based health maintenance organisations... the HMO dimension broadens the issue for debate from one of 'privatisation' to the development of mechanisms to improve efficiency in the supply of health services generally. Full exploitation of HMO type incentive structures, however, would require contracting for hospital services"(W. Laing 1985:48).

When Willetts moved to the Centre for Policy Studies (CPS) in 1986, Goldsmith became a Health Research Fellow at the think tank. The CPS published a pamphlet by a former government official who had been responsible for health finance within the Treasury. This investigated the scope for an internal market, but raised the question of: *"How can affairs be arranged so that GPs have an incentive to see that their patients are cared for with economic efficiency...?"* (Peet 1987:13) The idea of GPs with their own budgets was beginning to spread, but by the time of the NHS Review was still in its early stages with no practical development. Once such ideas were brought to the Prime Minister's attention by Willetts, he used Goldsmith and Dr Robert Gumbiner³⁴, the American HMO "pioneer" (Nelson 2009) and others within a group of people that he had developed to convince the Prime Minister that such a scheme could work in practice despite her scepticism³⁵. The Prime Minister held a seminar with doctors at Chequers in May 1988 and her Policy Unit produced ideas for GPs, as

³⁴ Robert Gumbiner founded the Health Maintenance Organisation FHP in 1961 as a pre-paid health plan because he objected to fee-for-service health care. In 1983 FHP obtained a contract to provide health services for a fixed fee under the state-funded Medicare programme for citizens aged over 65 years.

³⁵ Interview: Goldsmith 6 May 2009, Willetts 4 July 2006

well as hospitals, to be able to opt out of district health authority(DHA) control and manage their own budget. The attraction for Thatcher was that “the patient would be able to choose between a GP who held his own budget or one who worked under the DHA”(Thatcher 1993:614).

A Purchaser-Provider Split

The Stanford University Professor Alain Enthoven was invited to England in 1984 by the Nuffield Trust to study the operation of the NHS. In 1985 he produced a suggestion for a purchaser-provider split within the health service, to create an “internal market” (Enthoven 1985). This suggestion was heavily promoted by the sponsor, and as part of this Enthoven met with a number of politicians and policymakers, including John Redwood and David Willetts from the Prime Minister's Policy Unit (Timmins 2001:456). Then an enterprising health authority manager, Alasdair Liddell³⁶, led what became known as the "Rubber Windmill exercise"³⁷ in East Anglia in which the local health service ran a mock-up of an internal market system. (Timmins 2001:456)

Also in 1985 the Chairman of the new NHS Management Board which had been created as part of the Griffiths management reforms, took Enthoven's paper to the Board for discussion, so that he would prepared should it come up in subsequent discussion with the Prime Minister. The Board took the view that an internal market would be a distraction; not only was it already possible for districts to buy-in services, but the Board was concerned that a more complete internal market might revert the NHS to the pre-war situation of patients travelling long distances for treatment. The priority was *"to deliver on the basis of agreed programmes rather than diverting too much attention to the study of alternative models"*(Edwards and Fall 2005:36). This demonstrated a strong resistance to further change, even at the highest level within the new management structure of the NHS.

³⁶ Chief Executive, East Anglian Regional Health Authority, later Director of Planning, Department of Health

³⁷ Interview: David Willetts, 4 July 2006

The Prime Minister's initial response to an internal market was also negative, as she thought that it would do little to address the Government's aim to make public services more responsive to their consumers(Edwards and Fall 2005:57). With the addition of GP Fundholding this concern was, at least partially, overcome.

After the 1987 General Election, and before the 1988 Review was announced it seems that the Secretary of State for Health, if not the Prime Minister, was already thinking of ways in which a market might be developed in the health system. In early October 1987 the six DHSS ministers had a political "thinking day" at Chevening House. Following the ministers' discussion of health policy Edwina Currie recorded in her diary that Moore and Thatcher want: *"to 'meld' the state and the private sector by getting the NHS to behave more like a private operator. If one has spare capacity, the DHA can "sell" it to others or to the private sector. They're thinking of Bart's which is planning to lease a whole wing to the private sector*³⁸." These initial thoughts from health ministers were focused on income generation by NHS providers, rather than on creating an internal market or otherwise empowering patients, but a similar scenario was developing by another means.

People

In the story of the genesis of the internal market I have identified just three "veto players" within the political arena (Tsebelis 2002); those who might realistically have altered the course of events and led to the production of a very different set of proposals for the NHS. The first, of course, is the Prime Minister, who began to take a very active interest in long-term reform of the NHS from 1986. The second was the new Secretary of State for Health and Social Services, John Moore; a "Thatcherite" appointed immediately after the Conservatives 1987 General Election victory. The third was David Willetts, who had been acting very much in the "policy entrepreneur" role of the Kingdon model of agenda setting, bringing policy ideas from outside Government to the attention of the Prime Minister and others since 1983.

Margaret Thatcher

³⁸ Edwina Currie: Unpublished diary extract for Monday 5th October 1987 (Annexe)

Brian Edwards³⁹, one of the new Regional General Managers of the NHS, reports that Thatcher's exasperation with the NHS was made very clear during a dinner with the NHS Regional Chairmen in September 1986: *"Why is it that with all the extra investment, waiting lists have gone up?"* She asked. According to Edwards she made it very clear that she was not impressed.(Edwards and Fall 2005:56) The arrival of reports in the mid-1980s forecasting long-term rising demands that would be placed on the NHS (Nicholas Bosanquet 1985a; Chew 1986) against restrictive spending plans was followed from the summer of 1986 with the Prime Minister requesting ideas for reform from both the Department of Health (Edwards and Fall 2005:47; Thatcher 1993) and the Centre for Policy Studies(Willetts 2006).

By the time of drafting the 1987 election manifesto, however, the Prime Minister believed that she did not yet have the ideas in place: *"there were still too many questions unanswered"*, and she was, anyway, reluctant to add health reform to the manifesto list of areas of the welfare state proposed for fundamental reform(Thatcher 1993:571). Thatcher held the NHS in much higher regard than she did other aspects of the welfare state, particularly education, which was to be targeted for reform again in 1987, as it had been in 1979. She believed that the NHS provided enviable quality at a modest cost, and was happy to repeatedly defend it in a way that she could not bring herself to do for schools. Professor Walter Holland recalls an incident during the 1988 review of the NHS when David Green from the Institute of Economic Affairs (IEA) put forward ideas for an insurance-based system of healthcare: *"Both Maggie [Thatcher] and Roy [Griffiths] slapped him down very hard and said whatever happens we never want to go back to pre-war conditions"*⁴⁰. The NHS, she believed simply: *"lacked the right economic signals"* to respond effectively to the task of balancing demand with the funds available(Thatcher 1993:606-607). The role of incentives was an important theme for Thatcher, but she was concerned in the context of healthcare that misplaced financial incentives could have politically disastrous effects. Willetts⁴¹ and Goldsmith⁴² both recall that she was particularly concerned that giving budgets to GPs

³⁹ Regional General Manager, NHS Midlands Region

⁴⁰ Interview 26 May 2009

⁴¹ Interview 4 July 2006

⁴² Interview 6 May 2009

could produce moral hazards, with GPs selecting low-cost patients, or diverting NHS funds to their own enrichment.(Goldsmith 2009; Isom and Kandiah 2002:31).

Goldsmith was asked by the Downing Street Policy Unit to write a paper explaining to the Prime Minister why practice-level funding would not be dangerous, provided that any savings could be invested in the practice: *"What she thought was that they'd all be driving around in Porsches, they'd live off their savings"*⁴³. The Prime Minister's fears for the potential impact on risk sharing for high-cost patients and adverse selection led to the fundholding scheme being initially *"quite narrowly defined for only a small number of cold surgeries"*⁴⁴.

Thatcher's general antipathy towards the NHS, which compared well with her hostility to the education system and local government, was combined with strong support for the private alternative. This was something that, despite advice of potential electoral damage, she was keen to make the case for. In the closing days of the 1987 election campaign, in a national television interview, Thatcher responded to a question suggesting that in her support for private care she might be insensitive to the health needs of ordinary people, saying: *"No, along with five million other people ... I pay my way for private health...I pay three times: I pay my whack in taxes, I pay personally when I go to a doctor, and I forgo 20 per cent of my salary which falls back into the Treasury"* (Cockerell 1988:329).

Showing little sign of electoral fear on health policy Thatcher recalls that in the election campaign: *"I refused to be apologetic for the fact that I used private health insurance to have minor operations done speedily...I was not going to back down, however much others around me hoped that I would stay silent on the matter in the interviews when it was bound to be raised ... By the end of the campaign I had won this argument – and it was definitely worth winning"* (Thatcher 1993:585). Her support for health insurance was to resurface again a year later, when she was to force the subject onto the agenda in discussions of NHS reform. It was clearly a topic

⁴³ Dr Michael Goldsmith. Interview 6 May 2009

⁴⁴David Willetts MP. Interview 4 July 2006

on which she was passionately committed not only that she was right, but also that she could convince the public that she was right despite the warnings of her advisers.

John Moore

Thatcher clearly viewed Moore as a young, attractive face for her brand of Conservatism. In her memoirs she recalls appointing him as Transport Secretary in 1986: *"I had high hopes of John. He was of my way of thinking. He was conscientious, charming, soft spoken and in some ways he had the strengths of Cecil Parkinson – that is, he was right-wing, but not hard or aggressive."*(Thatcher 1993:563). Willetts also suggests that she may simply have seen Moore as a: *"nice, good smooth PR man who will help to lead the case on the NHS"*⁴⁵. The comparison with Parkinson is particularly interesting, as Libby, Moore's special adviser, recalls that Parkinson was first offered and rejected the post of Secretary of State at the DHSS following the 1987 election. According to Libby, however, Parkinson better understood the political situation in 1987 than Moore, and realised that he was being offered a *"poisoned chalice"*⁴⁶. The suggestion that Thatcher appointed Moore for his perceived presentational qualities rather than his Thatcherite ideological stance is reinforced by her subsequent decision to appoint Kenneth Clarke, a left-winger, to head the new Department of Health during the Review. Presentation mattered to the Prime Minister. When, after losing many inner city seats in the 1987 General Election, she asked Lord Young who she might choose to lead on inner city policy "Ken Clarke, because he looks like he lives in one!" he said. She laughed and agreed (Balen 1994:148).

John Moore's appointment to the DHSS came at a difficult time for the NHS and good management and presentation would be much needed. Financial difficulties within the NHS were mounting during 1987, but Moore interpreted these as the usual bids for more cash and warned the NHS Regional Chairman against *"public appeals for more money"* and used his Party Conference speech to emphasise the need for greater

⁴⁵ Interview 4 July 2006

⁴⁶ Interview 3 June 2009

efficiency rather than greater funding, and to develop income generation in the NHS and the public-private mix in health more generally (*Edwards and Fall 2005:59*).

As in 1979, the Conservatives once again had a Thatcherite minister in charge of the NHS. Although those who believe that appointing Moore to the DHSS was a strategic move on the part of Thatcher to privatise the NHS (as Moore had already led several privatisations in other sectors) are contradicted by close commentators, who saw this simply as part of her attempt in 1987 to bring on the next generation of potential successors to her, not least to reduce Michael Heseltine's chances of succeeding her as party leader (Fowler 2008:29). Furthermore, Moore appears to have played a crucial role in actually bringing the NHS to the crisis point at which another fundamental review had become inevitable. As a former Treasury minister he had lost none of his zeal for spending restraint when he joined the DHSS. Major has reported that Moore, in 1987 in his first annual negotiation with the Treasury took an unusual approach on behalf of his struggling Department and: "*bid for too little money in the public expenditure settlement, rather than too much*" (Major 1999:105). The winter crisis and industrial unrest that ensued led directly to the Prime Minister's decision for a review, albeit one that led to the internal market rather than to the insurance-based systems that most interested Moore.

Although the Review announcement in January 1988 was a surprise to the Secretary of State for Health and Social Security he was reportedly delighted, after she had previously turned down his requests for just such a review when he was appointed as Secretary of State the previous year (Thatcher 1993:608) (Lawson 1992:614). Until her appearance on *Panorama* there appears to be no evidence that the Prime Minister had committed herself to a fundamental review of the NHS, other than asking Willetts for ideas.

Moore's junior health minister Edwina Currie claimed that whilst Moore might have hoped to use the review to produce a shift to an insurance-based market in health care, this was partly thwarted by her clandestine close relationship to the then Chief Secretary to the Treasury, John Major, who was also a member of the small ministerial review team (Times 2002). She said of Moore that: "*If he had been a*

*stronger or cleverer politician, some of that might actually have happened*⁴⁷. Thatcher does, however, give Moore credit for some of the ideas that emerged despite moving him off the review team in July 1988 before its work was complete:

“There can be no doubt that John had made a very important contribution to the review. The idea of money following the patient, the distinction between purchasers and providers and the concept of self-governing hospitals all emerged in the review during his period as Secretary of State. Also he pushed hard for tax reliefs [on private medical insurance]...”(Thatcher 1993:614)

Most accounts suggest that Moore’s performance as Secretary of State at the DHSS suffered after his winter bout of pneumonia, leading Thatcher to split his Department in July 1988 leaving him with Social Security and Kenneth Clarke with Health(Timmins 2001:460).

Whilst Moore was fully committed to the NHS Review, and had requested just such a review upon his appointment, his lack of experience in health policy appears to have meant that he had no clear direction. David Green, from the Institute for Economic Affairs, was one of a number of people who were given security passes for the Department in order to question officials and pass ideas to Moore. Green recalls that nothing came of this unusual way of working⁴⁸.

David Willetts

All accounts show a central role for Willetts in putting the internal market and general practice fundholding, and supporting the concepts thereafter. Willetts recruited two doctors as informal advisers, Clive Froggatt and Mike Goldsmith, to reinforce his arguments and demonstrate their practical viability to the Prime Minister. Willetts also possessed a particularly historic approach to policy, seeking to

⁴⁷ Interview 24 May 2012

⁴⁸ Interview 28 June 2011

right the "wrongs" inflicted by both Bevan in 1948 and Joseph in 1974(Isom and Kandiah 2002:41-43).

He and John Redwood met over lunch with Enthoven at the Nuffield Trust(Rivett 1998:360), and Enthoven's work convinced Willetts that a funding formula that mitigated the risks of adverse selection if funds were held at practice level was a realistic endeavour⁴⁹. When the Office of Health Economics held a 1985 follow-up meeting to the 1984 Cumberland Lodge event at which Marinker, Maynard, and Bosanquet all appeared to be working towards a concept of budgets held at practice level in primary care (Teeling-Smith 1984), Willetts was among the participants. The meeting heard the journalist Katherine Whitehorn describe how patients would increasingly require efficiency and the latest technology in general practice to be combined with autonomy over their care needs. Maynard put flesh on the bones of the earlier idea of GP's having budgets covering both primary and secondary care, "*competing for patients*" and buying in services from both the public and private sector, whichever is the cheapest(Teeling Smith 1985:46). Willetts inclusion in these expert discussions of GP budgets and the possible operation of an internal market for the NHS, and his position within the Downing Street Policy Unit put him in a strong position to act as a policy entrepreneur when reform of the NHS came onto the political agenda in late 1987.

Conclusion

In the case of the 1988 Ministerial review of the NHS it is clear that there was a confluence of Kingdon's three streams of problems, politics, and policies as a window of opportunity for change opened. The NHS winter crisis of 1987/88 (despite annual increases in health spending since 1979), coincided with the presence of a Prime Minister who still had a substantial majority in the House of Commons, and a Secretary of State at the DHSS who was keen to change the health system. It seems unlikely that if any of these elements had been missing a fundamental review of the NHS would have taken place in the 1980s. Furthermore, Willetts played the important role of policy entrepreneur. Given the wide range of ideas being

⁴⁹ Willetts. Interview. 4 July 2006

presented to Moore it appears to have been Willetts who pressed the concepts that were to underlie the eventual proposals. Moore's special adviser says of Willetts that he was a regular visitor to the Department and that: *"John Moore liked him hugely, rated him"*⁵⁰ and that this was one of the few good relationships that Moore enjoyed in his time at the DHSS, where he otherwise appears to have provoked some hostility⁵¹. When responsibility for health policy was taken from Moore in February 1988, Willetts was in a strong position to maintain support for the internal market plans within the Review.

In a discussion of the events of late 1987 and suggestions that the NHS Review was a panic response to these Stephen Dorrell, who later became Health Secretary, has suggested that by the end of 1987 it may have been: *"true that there was real public unease about the Health Service, and if it was also true that there were a number of ideas around which were felt could offer realistic improvement to the way the Health Service was administered, it seems to me it's actually part of the politician's art to use events like that to create openings for change. It's what the Americans ... called 'triangulation'; using current events to drive through processes that you see as being desirable"*(Isom and Kandiah 2002:38)

Willetts argues that *"the political moment became ripe in late 87... there was a policy agenda around. We had been thinking for several years about what became known as the internal market, and there was a political crisis that required that we show we are doing something"*⁵². If it had not been for the NHS winter crisis of 1987-88, according to Dorrell, it is unclear that the subsequent path of reform would have been taken: *"Healthcare has always been an area of extreme political sensitivity, so I don't think it is by any means certain that anyone would grab hold of it if there wasn't a compelling need to do so"*⁵³.

In terms of the direction taken Willetts has suggested a historic logic to what the Government was offering general practitioners, and a lack of logic in the profession's

⁵⁰ Interview 3 June 2009

⁵¹ Edwina Currie unpublished diary entry 29 November 1987 (Annexe)

⁵² Interview 4 July 2006

⁵³ Interview 26 July 2011

response: Since the creation of the NHS the profession had been fearful that Bevan's ambition of a salaried service would eventually be fulfilled. What the Conservatives were offering was a settlement that would finally confirm their independence from the state(Isom and Kandiah 2002:37).

The internal market built on the development of general management in the NHS following the Griffiths Report, which would have affected the timing of when market-based reform became a practical possibility. Bosanquet also argues that the management reforms of the 1980s created an essential group of potential supporters for subsequent changes(Isom and Kandiah 2002:41). The decision to present "*Working for Patients*" (Dept of Health 1989b) as a revolutionary reform rather than an evolution from Griffiths was taken by the then Secretary of State, Kenneth Clarke, possibly as a measure to ensure that the changes were delivered on time(Isom and Kandiah 2002:44-45).

7. An Introduction to the Case Studies

The five case studies include four which produced a substantive and enduring change of direction. As a result households were making a significant new contribution to the services that earlier generations would have received largely or completely free of charge. This chapter sets out to demonstrate the individual significance of each change, and their mutual significance within a significant programme of relative retrenchment on the part of the welfare state, despite continued growth in state spending on these services.

The initial changes that set these services off in a new direction took place between 1983 and 1990, although in the case of dentistry a policy response took some six years to be put in place. The chronology of the changes is listed below:

1979

Prescription charge increased from 20p to 45p. The first increase since 1972

1980

Prescription charge increased to £1

Relief on employer-provided medical insurance announced

1983

Means-tested Supplementary Benefit made widely available to support people in private residential care

Three popular prescription medicines “switched” to pharmacy availability

1984

Quality regulation for residential care introduced

Health & Social Care Act: Opticians’ monopoly on spectacle sales ended and advertising permitted

1985

NHS Limited List of black-listed medicines introduced

NHS spectacles restricted to the poor and those with special needs

1986

Voucher scheme replaces NHS supply of spectacles

1988

NHS dental charges made proportionate to treatment costs

Spectacle voucher scheme extended to contact lenses

1989

Universal free sight tests and dental checks abolished

1990

NHS & Community Care Act gives local authorities a duty to promote independent community care provision

Tax Relief on Private Medical Insurance for Over-60s introduced

1991

Clawback on dental “overspend” fuels withdrawal of NHS dentistry

1992

First medicines switch guidelines

1993

Griffiths reforms of community care implemented, with local authorities as lead purchasers with a ring-fenced budget

1994

Range of medicines that can be switched extended

1996

Community care Direct Payments introduced

“Partnership” proposals for long-term care insurance published

NHS Dental contract shifts focus to children, and purchaser-provider scheme pilots

Scale of the Shift

The 1980s and 1990s saw large shifts in both the supply and funding of the aspects of care covered in the five case studies. Other than for the tax relief on private medical insurance (PMI), which had a limited effect on the market for PMI, these shifts continued beyond the 1990s in an ongoing transformation of the United Kingdom health system.

In 1983 the NHS and local authorities accounted for 59 percent of total provision of long-stay beds for the elderly; in 1996 they accounted for just 20 percent (Audit Commission 1997). The revenue from charges for local authority placements in private residential care homes rose from £8 million in 1985/6 to £595 million in 1995/6 (at 1995/6 prices), and private spending for both residential and non-residential care rose from £354 million to £1.9 billion. Over the same period public spending on residential care home fees also rose from £262 million in 1985/6 to £2.1 billion (Burchardt 1997). In 1986 opticians stocked around 200 spectacle frames. By the early 1990s they often stocked 3000 or more (Fulop and Warren 1993).

By 1994 the market for medicines sold in pharmacies reached £1.2bn, equivalent to one-third of the NHS drugs bill (Blenkinsopp and Bradley 1996). Despite increased charges revenues from NHS prescriptions remained below 10 percent of gross NHS spending on medicines throughout the 1980s and 1990s (Burchardt 1997).

Privately-paid dentistry quadrupled between 1988 and 1998 to one-quarter of all patients. Over the same period enrollees in the private Denplan scheme rose from

30,000 to 900,000, and overall private dentistry revenues grew from £181m to £991m(Laing & Buisson 1999)

By 1997, when tax relief on private medical insurance (PMI) for people aged 60 or over was abolished it was said to have reached an annual cost of £110 million, assisting about 550,000 people(Inland Revenue 1997). Following abolition the proportion of this age group with PMI fell from 9.2 percent to 8.8 percent, with an estimated 4,000 people losing cover(Emmerson et al. 2001).

Despite the scale of these changes it is important to note, however, that real-terms NHS spending rose steadily throughout the period: in the first Thatcher term of 1979-83 by an average of 3.9 percent per annum, in the second term 1983-87 by 2.1 percent per annum, in the third 1987-92 by 3.9, and in John Major's first full term 1992 to 1997 by 2.4 percent per annum. These averages do, however, cover some significant annual fluctuations. Between 1980/1 and 1981/2 real spending growth fell from 10.1 percent to 2.2 percent, it was then kept low (falling to 0.2 percent in 1985/6) prior to a jump to 4.4 percent in the pre-election year of 1986/7 and it stayed at around this level before falling to 0.7 percent in 1989/90, with growth as high as 6.4 percent in the three years of implementation of the internal market reforms up to the 1992 General Election (HC Debates 16 February 1998 cc492-3W).

As can be seen from these figures, the changes did not achieve a seismic shift in the public costs of the health services, but enabled ongoing increases to be contained whilst the private alternative was encouraged to grow in order to deliver additional capacity and enhanced quality. The case studies that follow will set out these shifts in more detail, although the focus is on the factors that generate the changes rather than their impacts, which became more significant over time. As in the discussion of the internal market proposals, drawing on Kingdon's policy streams theory, each case study will be used to identify the problems, people, and policies that may have come together to perhaps open and exploit a window of opportunity for change.

8. General Ophthalmic Services

Introduction

Whilst general ophthalmic services (GOS) may no longer be perceived as a "core" part of the National Health Service, this is a relatively modern development, as this service has popular origins that even pre-date the creation of the NHS. It was one of the most developed services under the National Health Insurance system of the early twentieth-century, covering 12 million adults, whilst children were covered under the School Medical Service. (Webster 1996:368-70).

Once the National Health Service came into being after the World War II a similar level of service as before was maintained. Not only were ten types of spectacle frames available free of charge, but a small selection of additional frames could be obtained for a small charge, with free NHS lenses, which became known as "hybrids"(ABDO 2008). This was deemed sufficient to avoid too utilitarian an image for the service, whilst trying to avoid an excessive boost to demand. Nevertheless, demand did exceed what the NHS could afford, and small charges were introduced in 1952, but with very little effect on demand until they were raised(Webster 1988:370-72).

In 1956 the Guillebaud Committee Report(Guillebaud 1956) expressed regret that spectacle charges had been imposed, as these would present a barrier to use, and called for a "substantial reduction" when NHS finances allowed(Klein 2001:27). Additionally, a special Social Services Committee chaired by R.A.Butler⁵⁴ had been set up by the Conservative Government after the 1955 General Election, to look at rising public expenditure. During its deliberations the Treasury urged the wholesale removal of dentistry and ophthalmology from NHS coverage. These drastic steps were not agreed due to the opposition of the ministers from the spending departments (Glennerster 2007:79). The fiscal crisis escalated, prompting the resignation of the whole Treasury ministerial team⁵⁵ in January 1958(Harris

⁵⁴ Home Secretary and Conservative Party Chairman

⁵⁵ Peter Thorneycroft (Chancellor), Nigel Birch (Economic Secretary), Enoch Powell (Financial Secretary)

2011:426). These events were to have a lasting effect both on how spending negotiations would take place in future (with much greater Treasury control) and on the 'sound money' debate within the Conservative Party.

In 1980 the Government included the abolition of free NHS sight tests in a Health Services Bill, but withdrew the proposal during the passage of the Bill, following substantial opposition amongst Conservative members of parliament (HC Deb 15 May 1980 cc1761-824). At the time both the Conservative Party and the Cabinet were far from united over an economic strategy that was producing high inflation, rising taxes, rising unemployment, and spending cuts. Ian Gilmour suggested privately that most of Thatcher's Cabinet was against her (Young and Trewin 2009:144), which meant that she must have had to choose her battles carefully.

Despite the climb down over free sight tests other aspects of opticians' services were also attracting political attention. The widespread practice of Resale Price Maintenance, by which manufacturers would set minimum retail prices had been forbidden since 1964, as part of a general move to promote competition. The General Optical Council, however, avoided price competition between opticians by stipulating a ban on advertising, which it actively enforced. In two reports during the 1970s the government's Price Commission had raised concerns over the impact of this restriction on the price of spectacles and on competition between opticians (Price Commission 1976, 1979), but no steps were taken to address it.

Experience comparing American states that allowed optician advertising against those that prevented it demonstrated significant price reductions (Hailey 1980), and with the rise in air travel during the 1970s⁵⁶ personal experiences from other countries were beginning to play a role in the debate over health policy. In 1979 the former Conservative health minister, Baroness Hornsby-Smith told the House of Lords that the one optician on the Maltese island of Gozo enjoyed a thriving trade in providing spectacles to visitors from the United Kingdom, using prescription lenses

⁵⁶ Laker "Skytrain" offering low-cost flights to New York launched in 1977BBC, 'That Was Then: Sir Freddie Laker', (2012; London: BBC, 2002)..

supplied from England, but selling the frames at one-third of the English price (HL Deb 08 November 1979 c983)

The scope for a market in spectacles was a topic of debate amongst the ophthalmic profession itself. When a letter to the British Medical Journal in 1978 suggested that Britain should return to making reading glasses widely available in the retail sector, as was the case in other countries and had been before the NHS, two ophthalmologists wrote that this "naïve" view: "would turn back the clock in Britain 50 years and would be responsible for loss of sight in quite a proportion of the elderly population"(Williamson and Doig 1978). To the contrary, however, a specialist from the Royal Eye Infirmary in Plymouth responded that whilst it might be "convenient and desirable" to combine spectacle fitting with sight testing: "On the other hand is it not an unwarranted interference with personal liberty to prohibit the sale of ophthalmic lenses to the public? We do not prohibit the sale of many drugs such as aspirin, which can lead to delay in the diagnosis of serious disease and which can moreover do undoubted harm to the patient if wrongly used, which glasses never do. And should we enforce routine medical examination, cervical cytology, mammography, WR, ECG, EEG, and a host of other useful tests on every member of the public? And if we did, who is to carry out the work?" (Payne 1978)

By 1983, however, the critical report from the Office of Fair Trading on the opticians' monopoly in the supply of spectacles(OFT 1982) gave the Government an opportunity to liberalise this particular market and begin an NHS withdrawal from the provision of spectacles, albeit whilst having to offer wider assurances on NHS sight tests, and on free spectacles for those groups who were still eligible. The Social Services Secretary, Norman Fowler said: "We believe that the present non-exempt customer will be able to obtain a wider range of glasses at comparable prices as a result of the proposed deregulation of the market". (HC Deb 28 November 1983 c657).

In the second reading debate Fowler also gave advance notice of a future voucher scheme for NHS spectacles:

"I should point out that when, as we expect, prices in the new deregulated market come down sufficiently, the Government would see great advantage in also allowing the exempt groups the right to choose more widely and either reimburse them or provide them with some kind of money voucher. This would have advantages both for the customer and the Department of Health. It is not at once obvious that a Government Department is best equipped to carry out the cosmetic role of designing spectacle frames, and perhaps that is one reason why there has been only one updating of NHS glasses since the early 1950s. (HC Deb 20 December 1983 c297)"

Fowler viewed the Conservatives' reforms of opticians' services in the 1984 Health and Social Care Act as a new model for social policy that is pursued from the point of view of the consumer rather than producers:

"In 1984 we ended the opticians' monopoly and taken off the ridiculous restrictions on advertising which prevented the public from shopping around for the best value. The changes had met with howls of rage from the profession; a host of cartoons in the press; but above all a reduction in price for the consumer"(Fowler 1991:197).

In 1986 the Government said that it was indeed satisfied with the effect of competition on the price of spectacles and used secondary legislation⁵⁷ to introduce a voucher scheme for children, and for adults with low incomes or complex spectacle needs. Henceforth the NHS might assist with the cost of purchasing spectacles, but would not provide its own. The vouchers came in a range of values between £2 and £66, determined by the complexity of the lenses needed (HC Deb 03 June 1986 c548W).

Private Sight Tests

Plans to restrict entitlement to free sight tests for the first time since the creation of the NHS, and to make dental charges proportionate to the costs of treatment were

⁵⁷ NHS General Ophthalmic Service Regulations 1986 (SI 1986/975)

included in a white paper on primary care(DHSS 1987b)⁵⁸ alongside a Bill for the parts that required primary legislation. This policy document, published on 25th November 1987 was focused on improving preventative care and a new contract for general practitioners, so the new restrictions on sight tests seemed to sit poorly with its overall emphasis.

In his statement to announce the white paper the minister for health, Tony Newton, presented the sight test change as a price to be paid for the other planned improvements in primary care. Another minister wrote in her diary that this was a "ghastly week" and that Newton was: "slaving away, teeth gritted, on proposals to charge everyone through the nose for their teeth..."⁵⁹. At this stage the NHS was entering a severe winter crisis, that was to lead to a wholesale review of the NHS early in 1988. The Department of Health was under the new leadership of John Moore as Secretary of State, who seemed less keen than his predecessors to gain additional funding for the health service.

Pushing the changes through Parliament was by no means easy for the Government, and the House of Lords made amendments that would have ensured the free sight tests were retained if they had been successful. Raison reports that: "A group led by Dame Jill Knight MP, and ranging across the political spectrum of the [Conservative] party, did all they could to get the government to accept the Lords changes, and by the time it came to eye tests the government's majority was down into single figures"(Raison 1990:165).

Nevertheless, the Government's plans survived and were implemented under secondary legislation in 1989⁶⁰. Other measures in the 1988 legislation enabled health authorities to engage in "income generation" schemes. These were plans that John Moore had raised with the other DHSS ministers on their "thinking day" at Chevening House in November 1987⁶¹. The aim was not only to generate income for the NHS, but also to assist with a change within the NHS towards a "consumer-

⁵⁸ This also included a proposal to extend the voucher scheme to contact lenses, which came into effect on 1 April 1988.

⁵⁹ Edwina Currie. Unpublished diary entry 29 November 1987 (Annexe)

⁶⁰ ⁶⁰ SI 1989/395

⁶¹ Edwina Currie: unpublished Diary entry 29 November 1987 (Annexe)

centred" and "professional" culture (NAO 1993). For all the dramatic changes in ophthalmic services, as with dentistry, the amount spent by the NHS remained substantial. By 1992 the NHS was still spending in real terms 80 percent of what it had in 1979(Timmins 2001:503).

Impact on the Market for Spectacles

Competition, however, did have dramatic market effects. The Office for Fair Trading reports that:

"The deregulation of the retail spectacles market since the 1980s not only led to an increase in the range and quality of spectacles (from 200 frames in 1986 to more than 3,000 and the development of features such as anti-scratch coating and tinted lenses), but an improvement in the quality of the service including increased opening hours, speed of service, and immediate consultations" (OFT 2009:9).

An analysis focused more on spectacle prices, however, found the evidence inconclusive, with significant initial falls, but rising prices from the mid-1990s(Davies 2004:15). The same study also found that the voucher scheme initially saw users choosing to pay a significant and increasing premium over the price of the least expensive spectacles. This peaked at a price differential of more than £70 by 1992, but then fell consistently until 2000(Davies 2004:17). Data does not exist to explain this trend reversal which might, for example, be caused by improvements in the quality of the lowest priced spectacles, or it might have been the case that those who had been paying the greatest premium gradually switched to using the voucher towards contact lenses instead of spectacles.

Impact on sight testing

The number of NHS sight tests grew rapidly during the 1980s, from 7.9 million in 1978-9, with a final surge to 11.9 million in 1987-88, the financial year during which

the new restrictions were announced⁶² (HC Deb 30 January 1996 c719W). The subsequent fall to 10.8 million in 1989-90 when the restrictions were actually implemented, was followed by a jump to more than 12 million per annum thereafter (HC Deb 4 April 1995 c1038W), about half of which were paid for by the NHS (HC Deb 27 January 1997 c115W).

Currie summarises ministers' thinking on the ophthalmic changes:

"All opticians are private businesses, and small businesses in those days ... The feeling was if we remove the subsidy to them they'd be OK, the patients would be fine. These are not life-threatening circumstances we're talking about ... When it came to opticians we thought sod it, they could do what they like, and indeed they have, and they've done very well since. Opticians gave us a lot of grief during the Bill's passage because of Jill Knight MP, whose husband Monty had been an optician. She harrassed us all the way through. I just found that exasperating because of her solid belief that the state should be subsidising a private activity like that. To me it was over the border.

My expectations were based on talking to a number of opticians in my own patch ... I said, what would you do as a 'come on' to get people into your shop, especially if there is another one opening down the road? And the answer was free eye tests. So I concluded that abandoning universal free eye tests under the NHS was not going to be a problem"⁶³.

The changes certainly had a strong effect in the short term. NHS expenditure on the General Ophthalmic Service fell by 30 percent in real terms between 1978/9 and 1991/2(Bloor and Maynard 1993), but saw steady growth again from 1992/3(OHE 2012).

Problem

In the 1980s the rise of a consumer culture was expected to place increasing demands on the NHS(Taylor 1983a). This was particularly pertinent in ophthalmic

⁶² The announcement was made in November 1987

⁶³ Interview: 24 May 2012

services, with the development of a wide range of spectacle frames and lenses. By the early 1980s the UK was operating one of the most restrictive markets in spectacles. This had led to the concerns expressed by the Prices Commission in the 1970s. Widespread complaints over the high price of spectacles in the United Kingdom led the Government to ask the Office of Fair Trading to investigate both the opticians' monopoly on selling spectacles and the General Optical Council's ban on advertising.

By 1983 the opticians' monopoly was probably unsustainable. In a House of Lords debate on the Office of Fair Trading Report, Lord Rugby, who had long argued against the monopoly on the supply of spectacles that had been given to opticians' under a 1958 Act said of opticians that: "when faced with the greatest reliance on these status quo tools, you comply or you go without, or, as many do, you go abroad to buy them. Over the years, Government have been in possession of a vast quantity of correspondence. Their vaults must be overflowing with complaints from the public on this one issue" (HL Debates 27 April 1983 c1005).

It is notable that the major changes of introducing competition and removing free sight tests coincided with particularly difficult financial years for the NHS; the Lawson public expenditure cuts after the 1983 General Election and mounting NHS financial difficulties that came to a head after the 1987 General Election. At these times the search for public sector economies and for sources of income was intensive. In responding to the April 1983 House of Lords debate on the Office of Fair Trading report the health minister demonstrated how complicated links existed between NHS spending on ophthalmics and the high price of private spectacles, as opticians were found to be using profits on private sales to offset declining NHS fees (HL Debates 27 April 1983 c1037). The loss of these sales by breaking the monopoly could, therefore, lead to demands to substantially increase NHS financial support to the General Ophthalmic Service. It would have been a major concern that dealing with the consumer problem might worsen the NHS financial problem.

People

Norman Fowler, Secretary of State for Social Services 1981-87

Fowler was widely seen as a thoughtful, strategic politician with a "political mind"(Balen 1994:109)and according to John Major "a safe pair of hands"(Major 1999:87). His approach to liberalisation of general ophthalmic services reflected this, with a cautious incremental process of liberalisation, restrictions on NHS provision, a voucher scheme, and eventually the abolition of free sight tests.

John Moore, Secretary of State for Social Services 1987-88

Moore arrived at the DHSS with aspirations for radical change. His ideas for co-payments, subsidies for private medical insurance, and for the NHS to sell excess capacity in the open market were shared with the other health ministers at their "thinking day" in November 1987. Each of these ideas was pursued, even after Moore lost responsibility for health policy in 1988. By the time Moore took over at the DHSS, the private market for spectacles had already expanded, with new corporate chains having entered the market.

Dame Jill Knight MP

The opposition to changes in ophthalmic services that caused most concern for the Government came from its own side, led by Knight, who was MP for Birmingham Edgbaston from 1966 to 1997. In 1980 she had won her fight against Conservative proposals to remove free NHS sight tests when the appropriate legislative clause was suddenly withdrawn (HC Deb 15 May 1980 c1767). Knight was made a Dame (DBE) in 1985. Her late husband "Monty" had been an optician.

At the Second Reading of the Health and Medicines Jill Knight complained:

"I must tell my hon. Friend with as much force as I can muster that it is insulting to tell a man who has been trained for three, four or five years at a university or at an eye hospital that he should give his professional, expert services free and make his money selling frames. That is an offensive thing to

say to him, that his professional expertise is worth nothing and that he must get his money by other means. It is particularly offensive when the Government themselves took away the ophthalmic opticians' customary sale of frames in the 1985 legislation. I listened very carefully to my hon. Friend this afternoon when he said that the Government had enabled people to take their prescriptions from the optician and go and buy their frames wherever they liked. That is what they do" (HC Deb 07 December 1987 c59).

Knight voted against the Government in 1983 on the second reading of the Health and Social Security Bill liberalising the ophthalmic market (HC Deb 20 December 1983 vol 51 cc366-367) and in the November 1988 vote to put the abolition of free sight tests back into the legislation after the House of Lords had removed this from the Bill. The Government majority was reduced to eight⁶⁴ (HC Deb 01 November 1988 cc959-60). Knight had worked hard over the summer to prepare the ground for this rebellion, and an Early Day Motion that she had tabled calling for free sight tests to be kept gathered the signatures of 60 Conservative MPs. Knight says that Government Whips threatened her that she would be removed from her role as Vice-Chairman of the Conservative MPs' powerful 1922 Committee, which she was, and as Chairman of the Health Committee, which she was not (Knight 1995:168-171).

Policies

Market liberalisation had long been a core theme for the Conservatives, and a retail market without price competition would have raised concerns in 1979. In this case, however, the Conservatives had to balance the need to satisfy the demands of consumers for better value spectacles against the risk that NHS opticians would require higher state funding in order to maintain a universal General Ophthalmic Service. Policies needed to address both a consumer and a fiscal goal.

⁶⁴ The Government's majority in the House of Commons following the 1987 General Election (excluding the Speaker) was 100

Vouchers

Vouchers had become a key theme for the public choice economists of the Institute of Economic Affairs. They had been arguing the case for voucher schemes, particularly in education, since the 1950s, but had been met with practical objections once a "new right" government had been elected in 1979 (Arthur Seldon 1986). Ophthalmics provided an opportunity to experiment. According to Willetts this was "a conscious decision to be radical, because it looked like quite a defined area where you could carry out a bold experiment"⁶⁵. Heavily restricted eligibility for NHS spectacles since 1984 meant that a voucher scheme would not carry the "deadweight costs"⁶⁶ associated with their use in education or medical care.

Discussion

As Klein notes, a cautiously incremental policy of privatisation: "fell most heavily on those services which – rightly or wrongly – have been perceived since the 1950s as most marginal to the purposes of the NHS: dental and optical charges" (Klein 2001:137)

In this case there was a clear incremental strategy on the part of ministers, that amounted to something more than muddling with a purpose. In 1983, whilst liberalising the retail market for spectacles, Fowler also suggested that if the liberalisation worked well and prices fell then the Government would consider a voucher scheme for those who remained eligible for NHS spectacles (HC Deb 20 December 1983 Col 297). Before a voucher scheme could be introduced, eligibility for taxpayer support had first to be restricted, and supply-side competition developed. This competition then also allowed the Government to withdraw free sight tests believing that competing opticians would wish to continue to offer tests as an important part of the process of selling spectacles and contact lenses.

Whilst opticians services might now be regarded as peripheral to the NHS, at the beginning of the liberalisation process this was by no means the case. As a

⁶⁵ Interview: 4 July 2006

⁶⁶ Diverting public funds to those who would have willingly bought the product without the subsidy.

demonstration of the former it is telling how little this privatisation is covered in the histories of the NHS by Timmins, Klein and Rivett. A measure of the importance attached to NHS opticians services in 1983 is demonstrated by contributions to the House of Commons second reading debate on the Health and Social Security Bill. The Shadow Secretary of State, Michael Meacher MP, described the legislation in dramatic terms:

"This is a mean, nasty, spiteful and authoritarian Bill from an increasingly mean, nasty, spiteful and authoritarian Government ... there is one common thread running through all the unrelated elements ... I refer to the piece by piece mutilation of the welfare state. ... Clause 1 is a classic example of Right-wing Tory dogma in dismembering part of the NHS into its basic services only, while privatising as much as possible of the profitable elements in order to open up new markets for the Tory party's big business friends ... It is no matter to the Secretary of State, as he sits there smiling, that NHS frames, by being restricted to the poor, will become stigmatising as a badge of poverty for adults" (HC Debates 20 December 1983 cc304-305)

Ernie Roberts MP said:

"The Secretary of State becomes fouler and fouler in his privatisation schemes for the Health Service. The Tory Government, not satisfied with the murderous attacks that they have made on hospital services, are now determined to make the public pay through their eyes by making them pay more for eye care. About 3 million people will be deprived through the operation of the Bill. Those who suffer most will be people, such as those whom I represent, who are already beaten down into poverty by the Government".(HC Deb 20 December 1983 vol 51 c342)

The most significant barrier to change, however, came from the Conservative backbenches and despite its significant majority in the House of Commons in 1987 the Government came close to defeat on the legislation to introduce charges. They had already experienced this in May 1980; withdrawing the plans the Minister for

Health, Gerard Vaughan emphasised the role of Conservative pressure: "This is an important matter. In no way do we wish to create a deterrent for people seeking eye testing who need treatment. Representations were made—in many cases strong representations—by my right hon. and hon. Friends and people outside the House, but I am not aware that strong representations were being made by Opposition Members". (HC Deb 15 May 1980 c1781). The lost revenue would be recouped through other NHS charges. In fact, the clause dealing with charges was withdrawn at the last minute, after Jill Knight had visited the Table Office of the House of Commons to lay an amendment. According to the Speaker at the start of the debate: "We cannot pursue that now. It just disappeared" (HC Deb 15 May 1980 c1761).

Factors that supported change in this case, however, may have been threefold. Firstly, there was a very strong imperative to focus NHS resources where they were most needed. Currie commented, for example, that on sight tests "these are not life-threatening circumstances"⁶⁷ and Bottomley emphasised that these were not on the list of things, like accident and emergency services, that the NHS must provide⁶⁸. David Green, from the Institute of Economic Affairs, comments that whilst privatisation was the Government's "default action" this did not apply to the NHS except for dentistry and eye care: "They were both heading for privatisation. I remember that more or less taken for granted, or feeling it wasn't a problem"⁶⁹.

Secondly, the Government had a strong belief in market forces and the rise of consumerism, allied with the knowledge that the United Kingdom was a restrictive market compared to other countries. They could, therefore, make confident predictions of the market response to liberalisation and NHS retrenchment.

Thirdly, an opportunity existed to raise quality. There was little evidence that competition or the withdrawal from universal sight tests would cause harm to people's sight, and developments in spectacles and contact lenses were presenting new consumer opportunities.

⁶⁷ Interview: 24 May 2012

⁶⁸ Interview: 20 March 2006

⁶⁹ Interview: 28 June 2011

Bosanquet highlights the ophthalmic market as one in which "a combination of technical change favouring new kinds of customer, deregulation, and a very strong provider group" came together to provide a successful outcome⁷⁰. The comparison with what was to happen in dentistry, however, would be instructive. In ophthalmics a carefully managed incremental approach managed to create a situation in which rapid private sector growth was enabled, and consumerist demands on the NHS minimised. The final steps in restricting the NHS to a core service for those with either the most limited resources or the greatest clinical need were not taken until it was clear that a network of NHS opticians would continue to exist on the high street without additional funding.

⁷⁰ Interview: 12 May 2009

9. Long-Term Care of the Elderly

Introduction

Writing in the mid-1990s Pearson and Wistow identify: "A silent, if not surreptitious, shift in the balance between state and individual responsibilities for funding long term care that has taken place over the past 15 years" (1995). A key part of this shift, according to Rivett, was that: "The NHS was ceasing to see, as part of its function, the provision of accommodation for frail, elderly people" (1998:321). In the words of the Audit Commission the NHS had: "narrowed its role to that of a provider of acute care" (Audit Commission 1997:13).

Until the early 1980s the NHS and local authorities had been seeking ways to build capacity to meet demand for the ongoing care of the elderly who were unable to cope at home but who did not require the acute treatment facilities of an NHS hospital. Henceforth, from 1983, the state appears to have sought both to reduce its role as a provider of accommodation for these people, and then to limit its financial liability to fund their ongoing care within the context of an ageing population. The change of approach took place in the 1980s, although its implementation was largely delayed until the 1990s.

The section that follows summarises developments leading up to 1983 changes in the Supplementary Benefits system that prompted dramatic growth in voluntary and private sector provision of residential care, and highlights the consequences thereafter.

1948-1983 Building Capacity for Elderly Care

At the beginning of the modern welfare state the public sector did not possess anything like the infrastructure required in terms of hospital, hostel, and asylum beds. By 1953 some 15-20 percent of hospital beds were blocked by patients suitable to be discharged but needing other accommodation (HC Deb 13 Nov 1953 Col.1366). There was, therefore, extensive recourse to contracts with voluntary providers of

accommodation. The National Health Service was also beginning to employ specialist geriatricians to lead an initiative to rehabilitate elderly patients to prepare them for discharge from hospital, rather than leave them in long-stay wards. As can be seen from the quotation below the concept of a service to attempt to rehabilitate these patients was novel

It is notable in consideration of how boundaries have shifted in this case that the frail elderly were seen as "chronic sick" as distinct from the "medical sick", whereas over time a less generous "social care" and "health care" distinction has been developed; the use of the term "social care" brings the care within the scope of means-tested social security rather than within the ambit of freely-provided health care.

Early Days of "Geriatric" Care

House of Commons 1953

Miss Patricia Hornsby-Smith (Con. Health Minister):

Nearly all the regional hospital boards have now a specialist geriatrician whose task it is to see that these services are extended and provided throughout the area under his control.

Mr Reginald Paget QC (Lab): *What is a geriatrician?*

Miss Hornsby-Smith: *The opposite to a pediatrician. It is someone specialising in the care of the old.*

(HC Deb 13 November 1953 c 1361)

Much of the early policy was driven by a repulsion at the continued reliance upon old workhouses as local authority hostels for the elderly and mentally ill, and a desire to provide more appropriate care. Wider awareness of conditions in these places eventually generated serious demands for better standards of care. Townsend's survey of residential care (Townsend 1962) was hugely influential, throwing light on conditions that the public and policymakers were either unaware of or ignoring. This was followed by the 1967 "Sans Everything" report (B. Robb 1967), which revealed appalling treatment of the elderly and mentally ill in long-stay institutions. After the publication of these reports both Townsend and Robb were active in campaigning for substantive change. Pressure for improvement in the quality of care, however, came on top of the increasing pressure on capital funding to meet longstanding plans to increase the quantity of elderly care. This included the progressive closure of old workhouses (HC Deb 11 July 1967 Col 549). At the end of the 1960s demands for change were reinforced following the official report from an Inquiry into the

treatment of patients at Ely Hospital, Cardiff⁷¹(Howe 1969). Nevertheless, concerns over the "warehousing" of people with long-term care needs persisted into the 1970s(Miller and Gwynne 1972). Bosanquet recalled working on nurses pay for the Prices and Incomes Board at the time and asking a Ministry of Health official to suggest a good mental health hospital that he should visit, only to be told "there are no good ones"⁷².

Lack of Co-ordination

As well as problems in the quantity and quality of care, there have also been perennial problems associated with poor co-ordination between the state agencies involved, prompting repeated ministerial intervention. In September 1965, for example, the Ministry of Health sent a "Memorandum on the Care of the Elderly in Hospitals and Residential Homes" to hospitals and local authorities. According to ministers they thus: "restated in more definite terms the responsibilities which both partners ought generally to accept. But it went further. It also contained a final section advocating joint planning and joint operation of the two services, and it suggested in detail administrative arrangements for achieving these objectives"(HL Deb 15 November 1966 c1249-56). Successive governments were to repeat this message over the decades that followed.

Local Authority social services spending on residential care of the elderly increased only slightly between 1975/6 and 1978/9 (HC Deb 18 June 1980 cc557W), but by 1977 there were 108,000 residents aged over 65 in local authority homes and 24,000 in private homes (HC Deb 26 March 1979 c27W). Restrictions on public spending, particularly within capital budgets, following the economic crisis of 1975-6 meant that local authorities had to curtail investments in homes for the elderly, but were also reluctant to spend their current budgets on places in homes within the voluntary sector.(Timmins 2001:414) This meant that the longstanding problems associated with capacity were very real by the time of the 1979 General Election.

⁷¹ This revealed treatment that was so bad that civil servants in Cardiff and London attempted to prevent the Minister, Richard Crossman, from seeing the full report. He only did so due to the insistence of the Chairman of the Inquiry, Geoffrey Howe QC, and the Minister's Special Adviser, Brian Abel-Smith (Geoffrey Howe, *Conflict of Loyalty* (London: Macmillan, 1994):42)

⁷² Interview 12 May 2009

In 1979 the new Conservative Government remained committed to pursuing the "joint financing" scheme, that had been created by Labour in 1976; to use NHS funds to support patients' transition to external accommodation from NHS hospitals in joint local initiatives with local authorities, and a process of gradual handover through a tapering mechanism. In March 1983 the Government issued Guidance to health and local authorities to give a further boost to joint finance initiatives, supported by £11.5m of central funding. (HL Deb 14 March 1983 cc591-2WA). Such was the scale of the problem of capacity that in the first Thatcher term the Government began pilot schemes for the development of NHS nursing homes, although little came of this as it was not developed more widely. Even in 1992 the Kings Fund was still calling for this to take place as part of a solution to the on-going problem. (BMJ 1992).

Until 1983 the public sector provided most of the care that it funded; the NHS provided acute, community and long-stay beds, and local authority social services offices provided residential, day, and domiciliary (home) care. Additionally local authority housing departments provided housing with support (Audit Commission 1997:10).

Supplementary Benefit and Care Home costs

The economic circumstances around 1979 left many voluntary-sector homes facing financial difficulties, and individual providers started to seek discretionary support for their residents' fees from social security offices (Timmins 2001:414). In 1983, however, the Government opened floodgates for the expansion of private sector residential care provision, by using a Statutory Instrument to clarify the terms and limits for recourse to centrally-financed Supplementary Benefit to pay these accommodation costs (DHSS 1983a). Local authorities' use of discretionary powers under the National Assistance Act 1948 had been rising during the 1970s, to reach a total of £39 million a year by 1983, assisting 16,000 people. Klein says that in 1983:

"the Department decided to stop the creep. Each local social security office was asked to set a limit for the weekly payments, based on the highest reasonable charge for the area. The result was precisely the opposite of that

intended. The maxima quickly became the minima. More importantly, what had previously been a low-visibility, discretionary payment overnight turned into a highly visible, as-of-right entitlement"(Klein 2001:134).

This support through Supplementary Benefit was available to anyone who qualified in terms of an income and capital assessment, with no regard to their clinical or social needs. It was also only available for residential care, and not for NHS, domiciliary or day care. Supplementary Benefit was centrally funded and not by local government, and also did not come within the departmental spending limits of the DHSS as these benefits were demand-led by items such as unemployment.

During the remainder of the 1980s the independent sector in long-stay elderly care grew rapidly. By 1987 it accounted for the majority of this type of care. According to Day & Klein this dramatic growth can be put down to the 1983 "policy blunder" on Supplementary Benefit rather than any consumer-driven process or government strategy (1989:16). Timmins claims that the Government simply failed to estimate the impact of its decision within the context of an ageing population, which led private and voluntary care home to become the leading source of growth in public spending (Timmins 2001:414).

Day and Klein argue that government actions since 1983, show that it has continuously sought to escape its obligations on residential care and to limit the costs of the Supplementary Benefit change. These, they say, demonstrate that there was no "simple ideological moral" driving policy(Day and Klein 1989), particularly as the Government also engaged in steps that raised the costs of private providers, notably the imposition in 1984 of new quality standards on residential care providers(Day and Klein 1985). Indeed, Klein asserts that private sector provision would have risen regardless of what was happening within state funding and provision, given demographic change and rising household wealth in the 1980s(Day and Klein 1989).

Against the accusations of blunder and miscalculation it was clear that Conservative ministers in the DHSS did have a strong desire to support the voluntary sector. In 1981, for example, the Government said: "The primary sources of care for elderly people are

informal and voluntary ... It is the role of local authorities to sustain and where necessary develop – but never to displace – such support and care. Care in the community must increasingly mean care by the community" (DHSS 1981a:3). Ensuring the survival of voluntary sector providers was, therefore, central to Conservative plans for the future of the welfare state. Their failure would have done huge damage to these plans at the outset. In fact, the number of private and voluntary sector nursing and residential care beds grew by 242 per cent between 1983 and 1996(Audit Commission 1997:10). Early action had to be taken, however, to ensure that this rapidly growing cottage industry⁷³, was not profiteering⁷⁴ from Supplementary Benefit proceeds.

Wistow points to a strong "anti-statist" approach in the first Conservative term. The two documents "Care in Action"(DHSS 1981b) and "Growing Older"(DHSS 1981a) have been described as the "high water mark of an anti-statist bias"(Wistow 1988). For local authorities the 1983 decision on Supplementary Benefit Regulations meant that they faced less pressure to find capital resources to directly meet their statutory obligations under Part III of the National Assistance Act (1948) to provide accommodation for those who need it(often known as "Part III Accommodation), but could do so indirectly through the use of Supplementary Benefit which was centrally-funded by the DHSS. Timmins refers to an "unforeseen effect" of nationalising the funding of care home accommodation which had previously (with limited uptake) been almost wholly dependent upon private fees paid directly by residents. For NHS hospitals too, wishing to reduce bed-blocking and the need for long-stay geriatric wards, this was also a significant breakthrough due to the boost to private-sector capacity (Timmins 2001:424).

⁷³ Corporate providers amounted to just 3.7 of residential care home places in 1989 Laing & Buisson, *Laing and Buisson (1989), Care of Elderly People Market Survey 1989/90* (London: Laing & Buisson, 1989).

⁷⁴ A random survey of individual care home finances in the 1980s demonstrated huge variations in profitability.Irvine Lapsley and Sue Llewellyn, 'Government Policy and the Changing Market in Residential Care for the Elderly: A Financial Analysis of the Private Sector', *Financial Accountability & Management*, 8(2), Summer 1992, 0267-4424 \$2.50, 82/2 (Summer 1992), 97-113.

The number of NHS hospital geriatric beds had been static during the 1970s, but fell by almost 20 per cent during the following decade and a further 40 per cent during the 1990s (Crisp 2002). The chart shows the fall in NHS elderly beds in general wards against the growth in private nursing home places (Audit Commission 1997:12). The costs to the state of residential care rose from £39 million in 1982 to £489 million in 1986, and continued to grow rapidly thereafter (Higgins 2004:156).

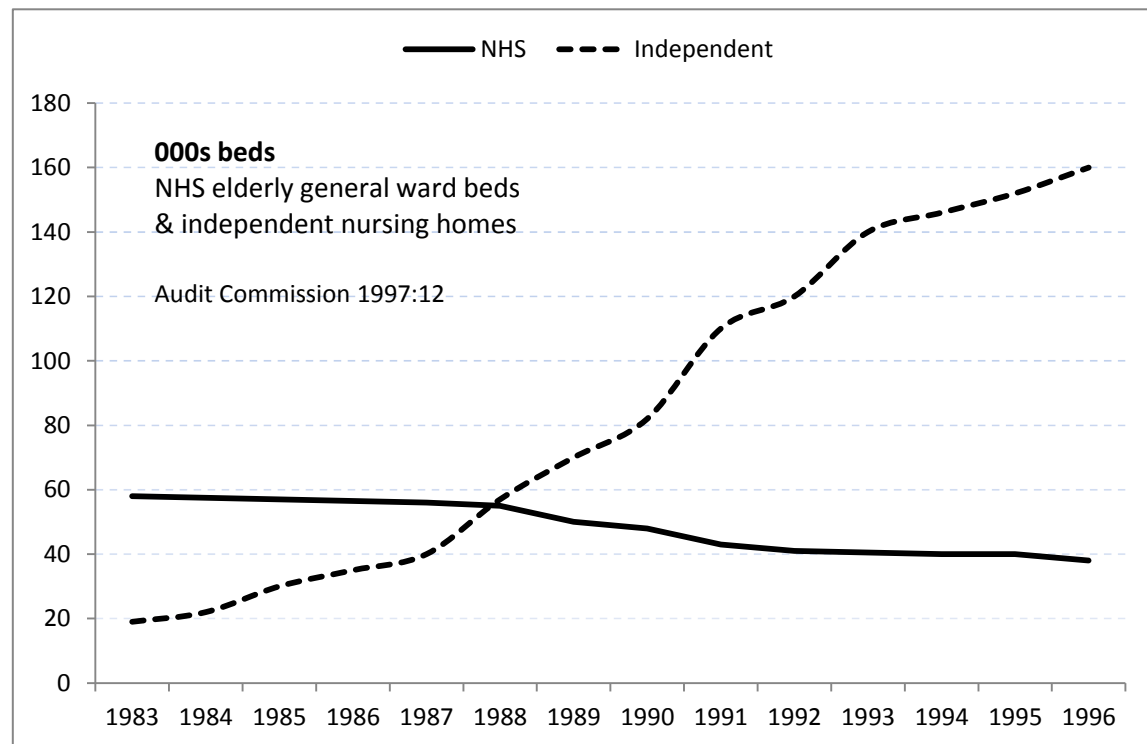


Table 3 NHS & Independent Beds 1983-96

According to Bottomley, part of this shift away from NHS provision was brought about by health authorities choosing to buy places in nursing homes; meanwhile social services were also moving people into private homes: "It was amazing that more people didn't realise what was going on, but it meant that by the time their successors came along there were no longer the beds in the health service, and the health service did not pay for their care⁷⁵".

Sir Roy Griffiths' Report on Community Care (1988)

Following the Griffiths Report on NHS Management (Griffiths 1983) Sir Roy Griffiths became a regular adviser to Thatcher, with sufficient influence over the Prime

⁷⁵ Interview 20 March 2006

Minister that the Health Secretary threatened to resign in 1986 if this position became formalised at 10 Downing Street (Gorsky 2010:20). In December 1986 Griffiths was commissioned to undertake another inquiry, this time into the use of public funds in community care.

The Griffiths Inquiry was by no means the only thorough consideration of the situation in community care at the time. The decision to turn to Griffiths for a second time followed a damning report from the Audit Commission on the situation in the provision of community care (Audit Commission 1986). The Firth Report and Wagner Report were completed whilst the Griffiths Inquiry was underway. The Firth Report had come to the conclusion that public funding should be channelled through local authorities (DHSS 1987a), and the Wagner Report that residential care should form a "positive choice" within a spectrum of care, rather than form a default option for long-term care (Wagner 1988).

During the Griffiths Review a pamphlet from the influential Conservative think tank, the Centre for Policy Studies, saw potential community care reforms as a pathfinder for an internal market in the NHS, saying: "Whatever conclusions the Griffiths Inquiry comes to it will probably recognise that although it partly arose by accident, the growth in social security-financed private provision for the elderly, mentally ill, and handicapped should be maintained: Indeed, it could be a useful precedent for other parts of the NHS" (Peet 1987:21)

For all the Conservatives' concerns, therefore, Griffiths recommendations for local authorities to become an enabling authority, and to offer people more involvement and choice in decision making fitted well with the ideology of the time. Nevertheless, the arrival of the report in early 1988 coincided with the start of the ministerial review of the NHS, and it is unsurprising that the Government took more than a year to develop its proposals for community care.

Thus it was not until 1989 that the Government finally found an acceptable (partial) solution, based upon local authorities acting as purchasers within an open market for community care provision, with needs and means tests restricting access to state

funding; but the system would not be fully implemented until 1993. The longstanding veto on change, despite the obvious costs of delay, had been the Prime Minister, for whom giving the purchasing role to local authorities grated with her foremost concern to diminish the role of such state bureaucracies.(Timmins 2001:475). Her Government had, for example, taken powers to cap local authority rates in 1984, abolished the Greater London Council (GLC) in 1986, and introduced an Education Reform Act in 1988 that encouraged schools and colleges to "opt out" of local authority control. The new system was set out in a white paper in 1989(Dept of Health 1989c) and included within the 1990 NHS & Community Care Act.

Bottomley emphasises the importance to gaining Cabinet support for the community care reforms of moving funding from an open-ended Supplementary Benefit commitment to a ring-fenced budget: "By transferring the funds and ring-fencing them, then it was possible to give people a domiciliary package; three home helps a week instead of a nursing home has actually achieved value for money"⁷⁶.

The rapid growth in private and voluntary residential care provision was finally halted once the NHS and Community Care Act (1990) came into effect on 1st April 1993. By then local authority social services departments were expected to have a plan in place to take the lead responsibility for arranging social care, based on a clear assessment of individual needs. The change was supported by additional capped and ring-fenced central funding through a Special Transitional Grant. Shifting the focus away from residential care, the new arrangement applied equally to all types of care(Audit Commission 1997:11).

Alongside this new regime for means-tested "social care" the NHS continued to withdraw from the continuing care of the elderly. This was a point that was highlighted by the Health Service Commissioner in 1994⁷⁷, following a complaint from a woman whose 55-year old brain-damaged husband had been discharged from NHS care and into a private nursing home despite requiring on-going care. The

⁷⁶ Interview 20 march 2006

⁷⁷ The patient was actually discharged in September 1991, prior to the community care aspects of the recent NHS & Community Care Act coming into force, although this is unlikely to have affected the clinicians' decisions in the case.

NHS, the Commissioner had found, had withdrawn too far; this indictment resulted in the health authority refunding the fees incurred(HSC 1994), and further Department of Health Guidance to health authorities on NHS Responsibilities in such situations(Dept of Health 1995).

The story of long-term care is ongoing. Following the 1997 General Election the new Labour Government created another inquiry, in the form of a Royal Commission, which reported in 1999(TSO 1999), and when a Conservative-Liberal Democrat coalition came to power in 2010 it established the Dilnot Commission on long-term care funding, which reported in July 2011(TSO 2011).

Whilst concerns over standards of care and cost-shifting continue, the focus has moved onto issues related to the private costs of long-term care needs. The 1980s shift towards the independent provision of care, is now well established. In the section that follows I will once again apply Kingdon's three policy streams to consider the problems, people and policies that might have brought this shift about. Analysis of the genesis of the 1983 change of direction in the provision of elderly care is limited to a very small number of variables as the initial change itself was so small. It is, perhaps, the most extreme example of how simple a change of path can be, even if the repercussions are far from simple.

Problems

An Insufficient Supply of Care

The first issue facing the Conservatives was the very limited capacity to provide residential care against the rising needs of an ageing population. Dorrell recalls:

"When I first became an MP in 1979 one of the aspects of caseloads that used to be a regular event in my constituency surgery was people who had elderly dependent relatives who wanted to get them into care home settings; couldn't afford private nursing homes and, therefore, there was a waiting list for local authority Part III accommodation"⁷⁸.

⁷⁸ Interview 26 July 2011

Costs of community care

A central concern for the Treasury was that social security spending on residential care rose from £10 million in 1979 to £2,072 million in 1991 (Glennister 2007:208). This did, however, enable the NHS to withdraw from the expensive provision of long-stay geriatric beds. In 1982 the weekly cost of a long-stay bed in an NHS hospital was £222, compared to £118 in a private nursing home despite the fact that people of equal dependency would be found in each mode of care (AJ Culyer and Birch 1985:479). Nevertheless, this was an area of rapidly rising public expenditure, at a time when the Government was committed to reducing the burden of taxation.

Cost Shifting

The 1983 change in the Supplementary Benefit Regulations certainly did not improve the situation in terms of ensuring that people would receive appropriate care. Once recourse to central Supplementary Benefit funding became available for the purchase of residential care in the independent sector both the NHS and local authorities had a strong financial incentive to use this facility.

The boundary between the responsibilities of the NHS to provide free health care and those of local authorities to ensure access to means-tested social care has remained problematic even after social services departments had taken on a lead role following the 1988 Griffiths Report, and implemented in 1993. In 1997 the Audit Commission said that: "The first legacy of the 1980s that needs managing is the change to the cut off point at which the NHS stops providing care" (Audit Commission 1997;12). Both the NHS and social services departments were under severe pressure at this time, and the political priority for the NHS was to manage waiting times ahead of the impending general election.

Bottomley stresses that Griffiths was very aware of the difficulty that social care is means tested and NHS care free at the point of use, creating perverse incentives for households and hospitals: "families want to keep their near ones in hospital as long

as possible because it is free; the health service will do anything it can to get them off their backs and into social care where there is a means assessment"⁷⁹.

The growth of the private sector and increasing availability of residential care, however, brought the costs to households of means-tested support to the centre of political debate. The Conservatives had pursued the creation of a property-owning democracy, but means tested care in old age meant that property wealth played an increasing part in the means test, and properties were being sold to pay care fees. For the Conservatives this seemed to punish the prudent. At the Selsdon Park meeting of Heath's shadow cabinet prior to the 1970 General Election, Quentin Hogg had set out this concern in relation to disability benefit claims by the elderly: "If you are old and have not made provision, I think you are to blame. Every person ought to recognise that by the time he is 70 he will have arthritis or something else" (Conservative Party 1970:10). In dealing with the care capacity problem in the 1980s, the Conservatives had fuelled the rise of a lasting new problem over the private cost of care.

People

Norman Fowler

Fowler had been DHSS spokesman in Opposition, and retained the portfolio in government from 1981 to 1987. He was admired by Thatcher, not least because he had urged her mentor, Keith Joseph, to stand against Heath for the leadership (Balen 1994:109). Although not a "wet" Fowler was deeply unhappy with the Chancellor's wholehearted focus on tax cuts from 1983, supporting a more "balanced approach" to tax and spending policy: "I did not threaten to resign, but I did make it clear that I would not endorse changes I could not justify" (Fowler 1991:202). Fowler embarked on a wholesale review of the social security system, beginning with plans to replace the State Earnings-Related Pensions Scheme (SERPS)⁸⁰ with a system based on tax-relief for all private pensions, in addition to occupational pensions. Additionally, both

⁷⁹ Interview 20 March 2006

⁸⁰ This was additional to the basic state pension, and the policy was agreed with cross-party support in 1975.

Fowler and Thatcher favoured a system that would make pensions compulsory(Lawson 1992:592).

Fowler's tense relationship with the Treasury continued, given their fears over the potential costs of pension tax relief. Indeed, one of his own ministers had passed information on his social security plans to the Treasury, and when John Major was appointed as a DHSS minister, coming from the Whips Office, in 1985 Fowler was concerned that he was placed there as a "Whips' nark".(Major 1999:86-87) On 25th February 1985 a Cabinet committee was due to discuss Supplementary Benefits, but it emerged that the Treasury was seeking £2 billion of savings within two years from Fowler's review. Fowler cancelled the meeting, and the Treasury was eventually forced to concede before the social security review's green paper (DHSS 1985a)was published, but the total replacement of SERPS was abandoned by the time of the subsequent white paper (DHSS 1985b). Fowler had to agree to a more modest proposal, with no universal tax-incentivised replacement: "As long as I live I will regret having to abandon our plans to give an occupational pension to every worker in the country".(Fowler 1991:220-222)

Fowler evidently carried more weight with the Treasury than many departmental ministers. Lawson expresses concern that Fowler was shifting the emphasis of social security support away from the elderly, and onto families with children, not only because this "ran clean counter to the moral sense of the nation", but also because "any upsurge of popular feeling about pensioner hardship was bound to lead to renewed pressure for a general increase in the basic state pension, over and above indexation". Nevertheless, he did not argue against Fowler's general strategy on this shift as the battle over SERPS was a priority, and Lawson comments: "Whether it would have made any difference if I had is more doubtful" (Lawson 1992:595-596)

Nigel Lawson

According to Fowler: "From the start of his Chancellorship, Nigel Lawson made no secret of the fact that his ambitions were tax reform and lower taxes. Almost his first action was a post-election dawn raid in July 1983 on departmental budgets. The raid

netted him £500 million and over the next few weeks he made his strategy clear. He believed that lower taxes were the route to higher growth and more jobs " Due to the scale of spending by the DHSS, the largest of any department, Fowler remarks that: "It needed no great powers of prophecy to realize that Nigel and I were on a collision course".(Fowler 1991:202). John Biffen, the Leader of the House of Commons, told a journalist at the time that he thought Lawson was "mad" wanting ongoing public spending cuts and everything put into tax cuts(Young and Trewin 2009:193).

Lawson's battle with Fowler over the latter's demands for tax-breaks to encourage people to opt-out of the State Earnings Related Pension Scheme (SERPS) was rooted in a firm belief that the tax system should be neutral, rather than attempt to steer individuals' or firms' behaviour. Tax cuts should be easier within a neutral system than within a complex regime, as there would be fewer losers from the removal of tax breaks, but widespread gainers. (Lawson 1992:335). A proposal that the system should, therefore, be used to provide new support to pensions would have been anathema to the Chancellor. Lawson blames Fowler for persuading him to provide "excessively favourable" tax breaks for those who contracted out of SERPS(Lawson 1992:370), which lay at the root of a subsequent scandal involving the selling of private pensions to people who should have remained within SERPS.

Policies

Purchaser-Provider

By appointing Griffiths for a second time in 1986 the Government would have once again been expecting a managerial solution to the problems of long-term care. By the time of the Griffiths Inquiry into community care Enthoven had already written his influential article proposing an internal market mechanism for the NHS(Enthoven 1985), and the Conservatives were working on plans for a similar system for schools.

The real challenge for Griffiths was to determine who should be the lead purchaser of community care. Thatcher's opposition to giving greater powers to local authorities is sometimes cited to explain the Government's slow response to

Griffiths(Raison 1990:180), but this would have been offset by restricting their role to that of an "enabling authority" and insisting that the bulk of the additional funding would be spent in the private sector(Glennister 2007:208). The "enabling" role chimed with proposals made by the Environment Secretary, a close ally of Thatcher, in a timely (for Griffiths) pamphlet from the Centre for Policy Studies(Ridley 1988).

By the time Griffiths was commissioned to investigate community care a mixed market of supply had been developed, with substantial growth in the private sector. Without this proposals for a purchaser-provider separation would not have been a viable option. Dorrell notes that this had "started as a way of relieving pressure in the social care sector" before developing later in the health sector⁸¹.

A similar approach was taken with the introduction of community care "Direct Payments" in 1996; a voucher scheme through which those assessed as needing routine non-residential care could select and purchase this for themselves. The then health minister, John Bowis, told the House of Commons at its second reading:

"One of the principal aims of community care is to enable people to cope with their problems of disability or frailty so that they can remain in their own homes whenever that is feasible and sensible, and they wish to do so. Making that possible is the challenge to families, informal and formal carers, local, private, voluntary and public organisations and agencies. Today, we are taking a further significant step down the road of responding to people's wishes and enabling them to lead as normal a life as possible. Direct payments are a natural progression in community care towards that aim, giving users more control and more choice. They put the people who need community care services in the driving seat and allow them to make important decisions about how their needs are met" (HC Deb 06 March 1996 c372).

The Minister made it clear that the restriction to people with disabilities aged under 65 was just an initial step before the scheme was widened (ibid.c375). Again, this

⁸¹ Interview 26 July 2011

could be seen as a move in a new direction, towards similar developments thereafter within the NHS, made possible by the introduction of a separation of purchasers and providers (Hockley 2007). Indeed, this was one of the concerns expressed by Alan Milburn⁸² in the debate on the Bill, given that it was an "enabling" Bill whose coverage could be amended by ministers without primary legislation. He called on the Minister to: "make it clear that direct payments are to be used for social care services only, and will not be used as a substitute for health service responsibilities. That distinction is vital, since otherwise direct payments received by disabled people will be means-tested even if they have to be used to purchase services that they should be receiving free of charge" (ibid. c430).

Supplementary Benefit Regulations

Fowler may not have accurately forecast how successful the 1983 regulations would be in supporting the ailing voluntary and independent sectors, but he achieved his ambition of developing a diverse supply of care outside of the NHS and local government, and increasing overall capacity. In response to accusations of subsidising private sector care homes the Minister replied in 1984 that the Government desired "to encourage the voluntary sector" adding that if limits on boarding fees had not been raised: "we could not have found places for patients" (HC Deb 10 July 1984 c866). The existence of a policy to favour growth in the independent sector, and to allow the relative decline of local authority Part III accommodation is also suggested by the fact that in 1983 the capital disregard with respect to eligibility for Supplementary Benefit for those in independent care homes, at £2500 was more than double that for those in local authority accommodation despite representations calling for the Government to harmonise this differential (HC Deb 16 March 1983 c196W; HC Deb 16 November 1983 c496W).

Bottomley argues that the changes that allowed Supplementary Benefit finance to flow into the private sector during the 1980s actually "created a new market, which was useful. It got people out of hospital at what seemed like no cost to

⁸² Shadow Minister for Health

themselves"⁸³. According to Dorrell, this move "effectively abolished" the waiting list for local authority Part III accommodation: "the Thatcher government introduced the principle that social services payments could be used to access private care providers" for people on the waiting list for Part-III accommodation, "that was a quite conscious act of policy, to meet a need, without expanding the local authority provider sector"⁸⁴. Warwick Lightfoot, an economist and former political adviser to Lawson at the Treasury, is less positive, describing it as "the saga of care in the community" with a "perverse set of incentives that enabled local authorities to put people in private non-council care settings and all the bill would be picked up by the social security system, and there was no cap on it"⁸⁵.

Discussion

This presents an interesting case, in which the relative roles of accident and intent are by no means clear. If the 1983 change to Supplementary Benefit availability was a blunder, it proved to be extremely fortuitous in terms of Conservative ambitions for the welfare state. As a direct result, not only was the longstanding problem of residential care capacity addressed, but the NHS was relieved of much of the expensive problem of needing to provide long-stay elderly wards, local authorities became purchasers rather than providers of care, and a vibrant private market was created. It is a blunder for which Norman Fowler, one of the most careful and technocratic politicians of the Thatcher years, never appears to have been criticised. Superficially, however, the change soon put £1 billion of new costs onto the Supplementary Benefit (later "Income Support") system at a time of intense public spending control that had begun with Lawson's 1983 "raid" on departmental budgets after the General Election. Indeed, Lawson does not discuss the rapidly rising costs of residential care in his autobiography, and simply states that social security was largely "demand driven" and that the elderly population was rising (Lawson 1992:301).

⁸³ Interview 20 March 2006

⁸⁴ Interview 26 July 2011

⁸⁵ Interview 27 July 2011

Taking a historical view of community care of the elderly it does appear to be plausible to argue that 1983 was an important turning point. The inability of the public sector to invest in order to provide the capacity required had not been addressed. Once the public sector was transformed from a provider to a purchaser, however, the situation changed significantly and with lasting effect. Essentially it was the combination of two factors that appear to have generated this change.

Firstly, the catalyst was a relatively small change in the Supplementary Benefit rules that was motivated by a desire to maintain a level playing field in the supply of care, between local authorities and private providers, so that there was a system of state support regardless of whether someone was put into a local authority home or an independent home. This was a 1980s equivalent to the 21st Century concept of "any willing provider" that was introduced in 2006 to underpin competition in the market for NHS-funded care.(Dept of Health 2006).

Secondly, the Conservatives in the 1980s were strongly motivated to ensure that if any additional funds were to be spent they were not to be spent through local government. If residential care capacity was to expand then it would have to expand in the independent sector. Initially at least, recourse to Supplementary Benefit would provide the means to do this.

It is intriguing, however, that this expansionary policy should be pursued within such a period of fiscal restraint. Lawson became Chancellor following the 1983 General Election determined to make tax cuts, and recalls: "The urgent difficulty I faced on entering Number 11 was a very worrying surge in public expenditure. If uncorrected it would have meant increases in taxation or borrowing – or both".(Lawson 1992:282).

The example of elderly care highlights the complex nature of boundary shifts under the Conservatives. Whilst boundaries clearly did shift between 1979 and 1997, as they have before and after, it is not immediately clear whether these shifts have all been examples of politicians working within an organised anarchy, just muddling through as problems arise or whether they were part of a more strategic agenda akin to

“muddling with a purpose”. It may be a mistake to analyse policymaking at this time as a coherent whole. There was clearly an underlying tension between Lawson and Fowler, not only with regard to the wholehearted pursuit of fiscal control above all else, but also over the boundaries between Treasury and DHSS responsibilities for social security spending.

Analysts need to be alert to what Tsebelis refers to as "nested games" or games-within-games (Tsebelis 1990). For Lawson, social security formed an important part of his Medium Term Financial Strategy to reduce the burden of taxation. For Fowler it was part of an agenda to deliver reform of the supply side of the welfare state, and to raise the quality of care available. Wherever either saw an opportunity to pursue their agenda they would probably have taken it. Fowler was determined to create a system in which every worker would have an occupational pension to rely upon in old age, but was blocked in this ambition by Lawson. He did, however, create a system in which everyone could have access to residential care in old age should they need it. In 1980 his predecessor, Patrick Jenkin, had explained to the Social Services Committee that whilst NHS-provided health care should remain as it was, the provision of personal social services should transfer to voluntary, neighbourhood and self-care. The Committee was concerned that this "aspiration would be mistaken for achievement" (Social Services Committee 1980). During the 1980s Fowler ensured that for the first time there was sufficient capacity outside of the local authority sector to deliver on this aspiration. This is, perhaps, a good example of muddling with a purpose, in which the central player had an idea of the direction of travel, but prediction of what the next step would be depended very much upon the effect of the first.

The boundary shift that took place under the Conservatives did, however, increase the political profile of the financial impact that long-term care costs were having on household finances, so that the political focus shifted onto the intractable problem of people having to sell their homes in order to fund their care.

10. Paying for Medicines

Introduction

NHS patients have contributed to the cost of the medicines they need since 1952. Apart from the short period between 1965 and 1968, when a Labour government abolished and then reintroduced⁸⁶ the prescription charge, they have been a constant feature. In 1984, however, the Government suddenly announced a new approach to limiting the cost of prescribed medicines; the creation of a black list⁸⁷ of items that could no longer be prescribed under the NHS. The black list was introduced alongside the new routine of annual increases in the prescription charge, and new encouragement for prescription only medicines to be switched to pharmacy (P) so that they would be available for direct purchase within the market for Over The Counter (OTC) remedies. Each of these measures would have the effect, at least partially, of shifting the costs of treatment onto patients. Whilst increasing prescription charges was by no means a new approach in the 1980s, annual increases were and this have become the norm since. The formal encouragement of self-medication by increasing the range of OTC items was also a new direction, but it was the creation of a black list of items that the NHS would no longer pay for that was the most dramatic breach with the past. This combination of tactics has been described as "creeping privatisation"(Heath 1994).

The Limited List

In November 1984 the Government quite unexpectedly announced a change in general practitioners' terms of service; the creation of a "Limited List" of products that would be barred from NHS prescription. According to Klein this: "caught everyone by surprise"(Klein 2001;139). The list was "limited" inasmuch as it initially only covered a small number of therapeutic categories. This came just after the Greenfield Committee on Effective Prescribing(DHSS 1983b) had rejected the option

⁸⁶ It was reintroduced with exemptions

⁸⁷ The Limited List is a negative "black" list of non-prescribable items. The situation has however, been slightly confused by the issuing of a positive "white" list for reference, listing those products which are prescribable within the groups covered by the negative list John O'grady, *Medicines, Medical Devices and the Law* (London: Greenwich Medical Media, 1999):84.

of using a black list to control the NHS drugs bill. Both the British Medical Association (BMA) and the pharmaceutical industry had been reassured by ministers that this was not a policy that they were likely to pursue. In the event the BMA received just two hours advance notice of the policy announcement(Marks 2008:146).

The Chairman of the BMA, John Marks, claimed that the Government had reneged on a commitment after the Greenfield Report not to adopt a limited list, and that rather than have the Government pursue this centralising path doctors would be willing to operate a voluntary system of "generic substitution". Under the BMA proposal doctors would choose whether to allow the generic equivalent of a branded medicine and mark each prescription accordingly.

Marks claimed that the government's Limited List would force those who benefit from free prescriptions to pay for private prescriptions. He pointed out that: "The list as it stands is not a list of generic drugs; it is a restricted list of drugs from which many generic equivalents are excluded" (Marks 1984). In fact, the BMA Chairman even predicted "the end of the NHS", and the BMA Executive voted to boycott any discussions of the list with the DHSS(Marks 2008:150). Unsurprisingly the BMA received a degree of media ridicule for its extreme reaction to the proposals(Times 1984).

Before the list was finally introduced in April 1985 the Government consulted on the medicines to be included, with medical participation, and established a new Advisory Committee on NHS Drugs to provide the basis of a new process to manage the list for the future(Klein 2001). Despite the opposition of the pharmaceutical industry, which made a strange alliance with Labour and the BMA, the Government expected pharmaceutical companies affected by the new Limited List to try, where appropriate, to maintain sales through over-the-counter sales directly to patients(HL Deb 20 February 1985 c638). The Labour Party had decided to oppose the Limited List because, they said, it would amount to privatisation by stealth, as medicines banned from NHS prescription would only be available on private prescription (HC Deb 18 March 1985 c738).

The Secretary of State for Social Services, Norman Fowler, has described the debate with the BMA, the pharmaceutical industry, and the Labour Party over introduction of a Limited List of drugs as "the most intense of my health service battles of the mid-1980s". He says that: "For years ministers had been urged to cut the heavy drugs bill. By 1984 the bill had reached £1.4 billion and we were under political and professional pressure to reduce it". It is, perhaps, a measure of the significance of this change that Fowler should have found this particular battle so intense given the many in which he was involved. In establishing the Limited List, however, the Government had succeeded in making "the first statutory inroads into prescribing freedom"⁸⁸ (O'Grady 1999:81), and it was to be a new road that proved popular with all ministers thereafter. The Limited List and POM-to-P switches added significantly to the existing tactics available to ministers to limit the growth of the NHS drugs bill, alongside the existing Pharmaceutical Price Regulation Scheme (PPRS)⁸⁹.

In 1992, for example, a new system to facilitate the switching of medicines from prescription only status to one of pharmacy availability coincided with the development of a new and extensive list of non-prescribable items (Dept of Health 1992: Schedule 10) and of another list restricting the use of several other medicines to specified groups of patients and conditions (ibid: Schedule 11).

POM-P Switch

Under the Medicines Act 1968 the United Kingdom separates medicines into three categories: Prescription Only Medicine (POM), Pharmacy (P), and General Sales List (GSL). This represents a more cautious approach than in many other countries which

⁸⁸ In fact, a Joint Committee on Prescribing had been set up by the Ministry of Health in 1949, which later circulated a list to GPs of items thought appropriate for prescribing, without enforcement John Abraham, 'Partial Progress: Governing the Pharmaceutical Industry and the Nhs, 1948-2008', *Journal of Health Politics, Policy and Law*, 34/6 (December 2009 2009), 931-77.

⁸⁹ The PPRS is a scheme agreed in 1957 between the Government and the pharmaceutical industry, based on a limit to the rate of return on capital that companies can earn from sales to the NHS. It is designed to balance the interests of the NHS with those of an industry which plays a significant role in the UK economy. Ministers also decided in 1984 to reduce the maximum allowable rate of return within the PPRS.

split medicines solely between those for which a prescription is required and those which can be widely available on the high street.

The reclassification of medicines was not a new phenomenon in 1983, although it had been a rarity. Paracetamol, for example, was "switched" from prescription only status in the 1950s. In 1983, however, the Government gave significant new momentum to the switching process. first ibuprofen (Nurofen) and loperamide (Imodium), and then terfenadine⁹⁰ (Triludan) were "switched" from being available only on prescription to being available directly from a pharmacy, and a further nine medicines were switched between 1984 and 1991. In 1992 the system for switching was made faster and simpler, and five years later the European Union followed a similar route with the adoption of a "switch guideline"(Cranz 1999).

In 1994 the health minister, Brian Mawhinney spoke of progress in liberalising access to medicines:

"We are continuing to extend the range of medicines which may be supplied without prescription where this can be done safely. In January 1993, we introduced a new timetable to provide for reclassification within 12 months and an order—SI 1993 No. 3256—which will allow a number of medicines previously restricted to prescription control to be supplied as pharmacy medicines, was laid on 31 December 1993 and is due to come into effect on 21 January. From July 1994, we shall be increasing the opportunities for reclassifying medicines by making two orders a year"(HC Deb 11 January 1994 c118W)

The promotion of self-medication appears to be a triple-win in terms of benefits to the NHS with less pressure on general practitioners for minor ailments and on the NHS drugs bill, easier access to medicines for patients, and new sales opportunities for the pharmaceutical industry. Some commentators, however, suspect that the

⁹⁰ Terfenadine was switched back in 1997 following evidence that it carried higher risks than previously known Pagb, 'Pom-P Switches: Updated List 26 April 2012', in Proprietary Association of Great Britain (ed.), (London, 2012a).

latter has been the principle beneficiary, with more questionable impacts upon the NHS, the role of pharmacists, and patients(Prayle and Brazier 1998).

The pace of liberalisation increased significantly, with some 30 medicines being switched in the three years from 1992 (Rutter 2012). By 2011 the amount spent by UK households on OTC medicines had reached £2.3 billion. They bought 964 million packs of medicines, just slightly less in volume terms than the number of prescriptions (1,064 million)(PAGB 2012b).

The Prescription Charge

From 1979 the Conservatives pursued a policy of consistent, and initially dramatic, increases in the NHS charge for a prescription for the minority of users who did not benefit from an exemption.

As Shadow social services minister in 1977 Patrick Jenkin said:

"There is certainly little justification for Labour's continued refusal to increase prescription charges, which have remained unaltered since 1971–2. Even Mr Joel Barnett, Chief Secretary to the Treasury admitted that raising the prescription charge from 20p to 50p per item would produce an extra £45 million a year (Blackpool, 4th November 1977). Many people may question the sense of priorities which leads a Government to reject this source of revenue when, as pointed out by Dr Vaughan, Conservative spokesman on Health, there are large numbers of patients not receiving kidney dialyses who should be, and 3,000 patients die annually owing to the lack of facilities"(Conservative Party 1978:156)

Once in office the Conservatives introduced two dramatic increases in the prescription charge, firstly from 20 pence to 45 pence in 1979, and then to one pound in 1980. In response to the 1979 increase the number of NHS prescriptions dispensed went from an average annual increase of nine million, to a fall in 1979 of three million. This was the largest fall since 1968, when charges were reintroduced(OHE 1980).

In January 1980 Thatcher's Treasury Private Secretary, Tim Lankester⁹¹, provided her with a calculation of the breakdown of the Treasury's proposed saving of £120 million in 1981/2 through planned changes to prescription and other charges from December 1980. These had been included in an earlier note to the Prime Minister from the Chancellor and Chief Secretary to the Treasury, and included more than doubling the charge again to one pound, and imposing a new 50p charge on groups of patients who were currently exempt (Howe and Biffen 1980). Lankester's note⁹² says that doubling the standard charge to one pound would raise £29 million, imposing a 50 pence charge on people over state retirement age whose income meant that they did not qualify for Supplementary Benefit would raise £39 million. Thatcher wrote on the back of the note: "We have got to get economies", (Lankester 1980) and the Government backed away from the controversial changes to exemptions from prescription and other charges. Howe duly announced the increase to one pound in his March 1980 Budget statement. In the 17 years of Conservative government that followed, whilst the prescription charge increased each and every year, there was no restriction on exemptions.

In the context of an ageing population the exemption for people of state pension age or above would have an increasing effect on the value of the prescription charge, which by the 1990s was equivalent to less than one per cent of NHS spending (HL Deb 25 July 1997 c186WA). By 1996 this led the health minister, Gerald Malone, to question his officials whilst being briefed in advance of the latest announcement of an annual increase: "The guy came in saying 'good news Minister; 80 per cent of people don't pay it'. I said I suppose the ideal position would be if 100 per cent don't pay it? What's the point? This policy is so good that we've exempted 80 per cent of the population from its impact"⁹³. In fact, whilst Malone was Minister for Health the proportion of free prescriptions increased to 85 per cent, following a decision to

⁹¹ A civil servant, Lankester had also served as a Private Secretary to the Labour Prime Minister, James Callaghan, having previously been a Treasury civil servant and World Bank economist. He was knighted in 1994.

⁹² See Annexe

⁹³ Interview 15 June 2012

equalise the age of eligibility at 60 for both men and women⁹⁴ (HC Deb 12 March 1996 c777).

Problem

In the early 1980s the NHS drugs bill was rising by 5 percent a year, although over time the share of the drugs bill within total NHS spending had remained remarkably steady, and in fact had fallen from 11.1 per cent of the total in 1970 to 10.3 per cent in 1980(OHE 1980: Fig7). The growth of the drugs bill had been due to a rising number of prescriptions since the NHS was created, but from around 1980 its growth was also being driven by on-going increases in the average cost of the prescribed drugs(Abraham 2009:946). In 1983 the problem of the growing drugs bill, and particularly the increase in prices, was raised in a report from the House of Commons Public Accounts Committee(PAC 1984). Just before the introduction of the Limited List the health minister Kenneth Clarke told the House of Commons: "I do not know whether anyone can contradict this, but I have not yet met a doctor or a pharmacist in practice who does not agree that something ought to be done to reduce the growth of the NHS drugs bill" (HC Deb 18 March 1985 c742). In April 1985 when the Limited List was introduced the Government also reduced the maximum return on capital that the pharmaceutical industry could earn under the Pharmaceutical Price Regulation Scheme (HC Deb 08 December 1983 c473).

The problem for the Government was not a simple one. Whilst there was considerable pressure to contain the growth of the NHS drugs bill, and to be seen to do so following criticism from the Public Accounts Committee, the DHSS was also the sponsor Department for the pharmaceutical industry with a remit to maintain a successful research-based pharmaceutical industry. Policies would need to meet both objectives.

People

⁹⁴ In October 1995 the European Court of Justice upheld a complaint under Directive 79/7/EEC the UK could not discriminate so that men had access to free prescriptions at 65 years of age and women at 60. The UK government had argued that this was a matter of health policy that was not subject to the Directive (HC Deb 19 October 1995 vol 264 cc495-502)

Norman Fowler, Secretary of State for Social Services 1981-87

Fowler had a very harsh three years at the beginning of his lengthy term as Secretary of State for Social Services, dominated by the industrial dispute of 1982, which he describes as "a baptism of fire" and which led him to need an armed police guard for public engagements (Fowler 1991:168). In 1983 he also faced a Chancellor who was determined to cut spending and taxation over the lifetime of the Parliament. Fowler, however, is widely regarded as a careful tactician. According to Raison: "At the DHSS, Norman Fowler did not have about him any special charisma, but he had a competence and attention to political detail, in particular, that generally kept his department out of trouble"(Raison 1990:124)

Dr John Marks, Chairman, British Medical Association 1984-90

When the Limited List was announced in November 1984 Marks had only just taken over as Chairman of the BMA, but described himself as a "BMA man" with a "medico-political career" already dating back more than twenty years. When the announcement was made he was in Singapore with his wife on a BMA trip. In his absence the Chairman of the BMA's General Medical Services Committee (GMSC) decided to launch a high profile and strident campaign against the Government's plans, which clearly irked Marks (Marks 2008:146), and which appears to have pushed him towards an even more extreme position, which ultimately undermined the doctors' case⁹⁵.

The Policies

In terms of finding a means to curtail a growing drugs bill, the Department of Health's options were heavily circumscribed by two important considerations. Firstly, the British Medical Association would want to preserve doctors' clinical freedom to prescribe the drugs they felt most appropriate. Secondly, the Department of Health was also charged with sponsoring the research-based pharmaceutical industry,

⁹⁵ They were to make a similar mistake in August 1989 in response to the White Paper "Working for Patients"; an expensive advertising campaign against the reforms was undermined when the BMA used posters that personally attacked the Health Secretary, upsetting some of its members John Marks, *The Nhs - Beginning, Middle and End? : The Autobiography of Dr John Marks* (Oxford: Radcliffe Publishing Ltd, 2008) x, 279 p.:206-7)

which was both an important employer in the United Kingdom and a crucial source of valuable exports(Fowler 1991:193) but, as the Public Accounts Committee had shown, the existing price regulation scheme alone was proving ineffective. Any policy on the drugs bill would need to address both considerations. The focus, therefore, turned to means to encourage the use of generic⁹⁶ rather than branded medicines, which would have limited impact on new drug discoveries.

Generic substitution

In several countries it is legal for pharmacists to substitute a generic medicine if a doctor prescribes the branded equivalent; in some cases this even extends to therapeutic substitution where the generic is an alternative medication within the same therapeutic class. Generic substitution had been recommended in 1983 by the Informal Working Group on Effective Prescribing, known as the Greenfield Committee(DHSS 1983b).It was not supported by the BMA. The Government estimated that this would save around £30 million (HC Deb 18 March 1985 c747).

A Limited List

A comprehensive Limited List, known as a "white list" of those medicines that are prescribable across all therapeutic categories was rejected because it would harm incentives for pharmaceutical research in important categories of medicine (*HC Deb 18 March 1985 c744*). Nevertheless, the option did enjoy some support, given that it had been recommended by the The Royal Commission on the NHS on the basis that other countries operated such schemes(HMSO 1979).

In 1980 the Health Minister, Dr Vaughan, wrote that:

"Whilst I am continuing to study ways of encouraging effective and economical prescribing, I am not yet persuaded that a limited list would of itself achieve lasting economies in the cost of the National Health Service or

⁹⁶ Prescription medicines for which the originator's patent has expired. Generics can be sub-divided between those known by the generic name (e.g. Ibuprofen), often the International Non-Proprietary Name (INN) and branded generics (e.g. Nurofen), for which there is usually a substantial price difference despite their essential similarity.

necessarily be in the best interests of patients. In the few countries which operate such an arrangement, there does not appear to be conclusive evidence whether such savings as it yields are commensurate with the practical difficulties that there would be in introducing and maintaining it, notably in reaching agreement on what drugs were essential" (HC Deb 13 February 1980 c703W)

Such a list would, of course, also limit the clinical freedom of doctors. When the Greenfield Committee's 1983 report to ministers rejected the use of such a list, the Minister for Health, Kenneth Clarke, expressed agreement (HC Deb 22 November 1983 c144). But the Government's eventual policy was for a more selective negative list of items that could not be prescribed, simply listing those medicines to be controlled by central decisions. Fowler had seen such systems in Europe, in which: "certain branded drugs would not be prescribed at all when entirely adequate substitute generic drugs existed"(Fowler 1991:193). No drugs would be banned, only the branded equivalent of a generic.

Announcing the consultation on the drugs to be black-listed Fowler described some of them as mostly for "minor conditions" that might not even warrant medical intervention, adding that many of these were widely available without prescription but costing the NHS £120 million a year. Another group on the proposed list comprised tranquillisers and sedatives, whose use was rising rapidly and costing £40 million a year despite the presence of cheaper alternatives. He said:

"I see no reason, however, why in the two groups that I have set out the NHS should not limit itself to providing only the cheaper generic alternatives which are available ... If the patient still wishes to go for a particular brand name, he will have the alternative of buying it over the counter from his local chemist or else asking his doctor to prescribe it privately. This is the kind of system that applies in many other countries already".(HC Deb 08 November 1984 c226)

Discussion

Tackling the drugs bill is a popular activity amongst health ministers. It seems that both doctors and the public greatly overestimate the share of NHS costs due to medicines (Taylor 1983b:20), a miscalculation that probably also applies to many policymakers. If so, then it makes "action" on the drugs bill a useful activity for health ministers in their funding negotiations with the Treasury. The challenge for the Department of Health is to provide a concession to the Treasury on the growing Drugs Bill, whilst doing least to harm access to treatment or to undermine the attractiveness of the United Kingdom as a base for the global pharmaceutical industry.

The former health minister Gerald Malone describes a: "relentless process of negotiating the budget with the Treasury. You always had to give something, and quite often the something you gave didn't translate into the money the Treasury wanted. But it was all a shopping list of, 'well we'll put that up a bit and get a bit more money here'. It was just a negotiating process. I think quite often officials thought there was some ground they could concede that didn't matter very much". When it came to prescription charges: "They would know that 80 per cent of people aren't going to pay it, so what's the point? So it was a concession that was made without any thought to whether it had a policy objective. Just bargaining. The bazaar of the health care Treasury negotiations"⁹⁷.

In 1984 the DHSS was under intense strain in its management of the NHS. The industrial disputes of 1982-1983 had driven waiting lists back up after some success in reducing them since 1979; Ministers had been cutting NHS manpower for the first time in order to streamline the NHS bureaucracy; and the Griffiths Report heralded further administrative changes.

The lack of consultation with the medical profession over the November 1984 decision to create a limited list shows an interesting boldness on the part of the Government. As Klein notes, ideas to restrict prescribing "had been floating around a long time. Successive Governments had, however, flinched from the prospect of a head-on conflict with the BMA on this issue" (Klein 2001:139). Having won the 1983

⁹⁷ Interview: 15 June 2012

election, and determined to make a quick start in delivering efficiency in the public sector, DHSS ministers clearly decided to cross the rubicon. In doing so they faced the combined opposition of the BMA, the pharmaceutical industry, and the Labour Party.

Klein's analysis, however, is that this was "an accidental rather than a deliberate trial of strength with the medical profession – the limited list episode proved to Ministers that it was possible to take on the doctors without getting a bloody nose: a lesson Kenneth Clarke in particular was to remember when it came to implementing *Working for Patients*" (Klein 2001:140). Henceforth, a whole series of measures to control prescribing became possible.

In implementing the Limited List ministers balanced the interests of the NHS with those of the pharmaceutical industry, hence the decision to apply the restrictions to a small number of therapeutic areas, combined with new opportunities for direct sales of branded products to consumers. Furthermore, switches to pharmacy and general sales availability would help meet the rise of consumerism in health in the 1980s(Taylor 1983a) and ease the rising pressure on general practitioners from minor ailments that could be self-medicated. Switching medicines became an increasingly popular solution for health ministers under financial pressure, with support from the pharmaceutical sector: In early 2002 the Department of Health published a Treasury-commissioned report showing dramatic future increases in the NHS cost of prescribing statins for heart disease, rising from £700 million in 2002/3 to £2.1 billion in 2010(Wanless 2002). To coincide with this a list of 50 medicines, including statins, thought suitable to be switched from POM to P was released by the Medicines Control Agency(Pulse 2002). The switch process was further streamlined in 2002, and an NHS White Paper in 2003 "Building on the Best" (Dept of Health 2003)set a 10 medicines per annum target for switching. In total, between 1983 and 2012 there were some 80 POM to P and 50 POM to GSL switches.(Rutter 2012:807). In 2011 consumers spent £2.3 billion on over-The-Counter Medicines(PAGB 2012b).

Prescription charges seem to be little more than a means of raising a relatively small amount of money for the NHS from a minority of its users. They remain something of

an anomaly within the NHS, as a core part of health treatment that is charged for. Whilst the combination of the Limited List, rising NHS charges, and switches to over-the-counter availability shifted part of the increasing burden of the NHS drugs bill onto users, the increased ease of access to routine medicines has brought clear benefits.

This example of change bears some similarities with the liberalisation of ophthalmic services. Once again, by making the product more accessible to consumers they were not only meeting rising expectations of accessibility, but also driving customers to the pharmacists' shops where they would also be able to purchase other everyday items, which in turn might reduce pressure on NHS payments to pharmacists in the dispensing fee. Despite the heated battles in Parliament, therefore, there would be an eager market outside. As a strategic step the combination of the Limited List, to restrict NHS prescribing to exclude products deemed inappropriate or over-priced, and the beginnings of a process of switching medicines to pharmacy and general sales availability would have lasting effects. Although the pharmaceutical industry strongly opposed the Limited List, the new opportunities to continue to market their most important brands after patent expiry by switching them to over-the-counter availability would present a valuable new income stream.

Whilst the institutions of the BMA and the pharmaceutical industry resisted change, in this case the financial pressure on the DHSS and the rise of consumerism and a broadening role for high-street pharmacies made a mid-term battle with these institutions a viable proposition.

11. Tax Relief on Private Medical Insurance (PMI)⁹⁸

Introduction

The story of subsidies for private medical insurance (PMI) is one of an attempted boundary shift that did not happen. In fact the impact of government policies, whether to encourage or discourage growth in this sector, seems to be very limited in comparison to the impact of wider economic and social factors and debates over the quality of the NHS. This chapter investigates the factors involved in the decision to include PMI relief in the 1989 White Paper “Working for Patients” (Dept of Health 1989a). This was at odds with the other proposals which were focused on making the NHS more efficient and more responsive to patients through the use of quasi-market mechanisms. Whilst incentives for self-reliance were a consistent theme for the Conservatives, the promotion of private medicine at a time when the NHS was in difficulty and deemed to be in need of fundamental reform might reinforce perceptions of a lack of commitment to the NHS on the part of the Government that could only make the reform process more difficult. The genesis of the decision is, therefore, worthy of analysis because, whatever the impact of the change, it suggests an intention to achieve a fundamental shift in health system funding. The analysis is, therefore, concentrated on the decision to include PMI relief within the NHS reforms, that was debated and taken between the 1987 General Election and the summer of 1988.

Background

Private medicine had grown strongly in the 1970s and the early 1980s, but its growth then slowed, even following the introduction of tax relief on individually-purchased policies in 1990 (Emmerson et al. 2001). Despite an apparent lack of government influence over individual decisions to use private medicine and to purchase PMI the

⁹⁸ I have used the term Private Medical Insurance throughout, although this is taken to cover several forms of insurance for health-related risks.

political debates over the role of private healthcare within the health system and its relationship to the NHS have played a very prominent part in the history of the NHS.

The roots of modern PMI lie in the welfare reforms that took place at the beginning of the twentieth century. Compulsory insurance for workers under the National Health Insurance Act 1911 proved to be extremely popular with both the public and the medical profession in the decades that followed its 1912 inception (Brackenbury 1934). The scheme covered most employed workers, except those in non-manual jobs earning more than £160 per annum (Int Lab Rev 1924). Whilst private insurance played an important role during the operation of the pre-war National Health Insurance System the creation in 1948 of the universal National Health Service, funded from taxation and National Insurance Contributions, led many of the insurance providers that had previously existed to close down (W. Laing 1985). A few of those that continued combined to create the British United Provident Association (BUPA), which has thereafter dominated the United Kingdom market for medical insurance.

Tax Relief

The focal point for the discussion in this chapter is the introduction in 1990 of tax relief on personal subscriptions for medical insurance for people aged over 60 years. This was implemented alongside the "internal market" reforms of the 1990s, but abolished by Labour following the 1997 General Election. There has also, of course, been long-standing recourse to employer-provided medical insurance which, being one of many corporate "perks" has been less prone to political ideology⁹⁹.

Employer-provided cover played an important part in the growth of the medical insurance market, and replaced individual-purchased cover as the major component of the medical insurance market, in terms of numbers insured, from 1983 (G. Clark et al. 1995:10, Fig 4). By 2000 employer-paid insurance accounted for 69.5 percent of the United Kingdom market (Mossialos and Thomson 2004:73, Table 10).

⁹⁹ Relief on employer-provided PMI was introduced in 1980, but limited to those with annual incomes below £8500.

Growth in PMI may be linked to perceptions of delays to treatment in the NHS, upon which insurers tend to capitalise in their marketing (Harley et al. 2011). There is, however, little evidence to suggest that NHS waiting lists are positively associated with decisions to purchase PMI policies. In fact, Propper found evidence of the opposite effect for the period 1978-1996, but identified a time-lagged link with *levels of spending* on the NHS and with the availability of private doctors and hospital facilities (Propper et al. 2001). There is a logic to these findings, that low levels of NHS spending will only subsequently have an impact that makes private medicine a more attractive proposition, and that this may also lead doctors to engage in more private practice if the spending squeeze impacts upon their NHS workload and income. Furthermore, it is possible that specialist doctors may also encourage their patients to follow them into the private sector. Former health minister, Edwina Currie, put this rather bluntly when she said that: "When there is huge demand and when people are desperate, and where there are assets to be realised that could be used to pay for a service, you are bound to get the private sector interested; they will hold people over a barrel, and that's always the fear, and it's very clear to most people in the UK. People get very angry indeed at doctors who say: 'Well, I can't do this for three months, but if you pay me I can do it on Tuesday'".¹⁰⁰

As in the case of dentistry, the clinicians themselves do appear to play an important role in shifts in the take-up of PMI, suggesting an element of supplier-induced demand¹⁰¹. Thus changes in NHS consultant contracts, which had been the subject of political debate in the 1970s, along with the presence of NHS "pay beds", are relevant given that they impact upon the capacity of the private sector. The Labour Government of 1974-79 sought to use the renegotiation of the NHS consultants' contract as part of its political agenda to completely separate the NHS and private sectors, by reducing NHS consultants' freedom to also engage in private practice. Additionally, Barbara Castle's¹⁰² policy commitment to remove pay beds from the

¹⁰⁰ Interview 24 May 2012

¹⁰¹ For a discussion of supplier-induced demand in the agency relationship between doctors and patients, see the chapter by Evans in Mark Perlman, *The Economics of Health and Medical Care: Proceedings of a Conference Held by the International Economic Association at Tokyo* (London: Macmillan, 1974)..

¹⁰² Secretary of State for Social Services 1974-76

NHS appears to have spurred the development of private capacity outside the NHS and growth in the take-up of PMI (Foubister et al. 2006; D. Robb and Brown 1984). In 1979 BUPA faced the arrival of an important new product in PPP's¹⁰³ "six-week plan"; this offerws comprehensive cover at a reduced premium for treatment if the NHS wait was more than six weeks. This opened comprehensive insurance coverage to a wider population than had previously been possible, when lower premiums were tied to lower cover (Health Insurance 2009).

In stark contrast to the Labour Government's approach of the 1970s, and reflecting the large ideological divide between the main parties at the time, the Conservative Party had a strong commitment to private medicine at the time of the 1979 General Election. This included a pledge to reverse Labour's on-going abolition of pay-beds from NHS hospitals and the restoration of tax-relief on employer-provided insurance, which Labour had removed.

Shortly after the General Election the new health minister Dr Gerard Vaughan told the House of Commons:

"I believe strongly that the encouragement of private medicine is in the interests not of a select few people but of everybody, including those who rely—and who will probably always rely—on the National Health Service ...We are clear that every penny spent in the private sector releases a penny in the National Health Service sector, which may then be spent on areas which need it desperately, such as children, the mentally sick and care of the elderly." (HC Deb 25 May 1979 vol c1449-50)

The NHS Consultant Contract

Negotiations over Labour's plans to revise the consultants contract, under which they intended to increase consultants' commitment to NHS were so prolonged that the new contract was not agreed by the time of the 1979 General Election(Klein 1995:104). The negotiations had even pre-dated the Labour Government, having begun eight years previously under the Conservative Government led by Edward

¹⁰³ Private Patients Plan

Heath. In 1979 it was the strong support of Patrick Jenkin, the Social Services Secretary, for private practice by NHS consultants that broke the deadlock.

Firstly, the contract (proposed by the British Medical Association in 1979) would reduce the salary penalty taken by those who chose a "maximum part-time" NHS contract; a contract option that had enabled consultants to also engage in private practice alongside their NHS work. Secondly, in order to maintain sufficient incentive for consultants to choose a "whole-time" NHS contract, those who did so would, for the first time, also be permitted to undertake private work up to a limit of earning the equivalent of ten per cent of their NHS salary¹⁰⁴. Finally, the contract would reintroduce the provision that had been removed by Labour for a "part-time" NHS contract requiring just six NHS sessions¹⁰⁵ per week.

The response within government was mixed. The Secretaries of State for Scotland and Wales, where there was very little private practice, were deeply sceptical. The Scottish Secretary wrote to Patrick Jenkin saying that: "At best the NHS will be paying consultants who undertake private work more money for the same NHS contribution, at worst we will be paying them more money for less work"(Scottish Office 1979).

In conceding to the medical profession's requests, however, the Government was able to ensure that they were finally placated after their serious disputes with the previous government, and at no additional cost to the NHS. As Timmins notes, the contract would give the doctors an important "safety-valve when the government ... squeezed their NHS income"(Timmins 2001:384-5). Other than in easing the relationship between the Government and the consultants, the new contract was probably not beneficial to the NHS, particularly as the government had little means of policing consultants' NHS working time. This was to become a continuous cause for concern(Yates 1995). Rivett lays some of the blame for long NHS waiting lists, concentrated in certain specialties, in the 1980s with consultants private practice:

¹⁰⁴ The option of private practice for full-time NHS consultants was, in fact, developed in 1974 by the health minister, David Owen, but was stopped by the DHSS Secretary of State, Barbara Castle (Barbara Castle, *The Castle Diaries, 1964-1976* (London: Papermac, 1990):500).

¹⁰⁵ A consultant clinic "session" is a clinic at which a consultant is scheduled to attend, lasting up to a maximum of a notional half day.

"Private health care was particularly common in some surgical specialties, such as ophthalmology, heart disease and orthopaedics. Waiting times for an NHS outpatient appointment in these specialties were usually lengthy, and further time was spent waiting for admission ... two-thirds of private work was undertaken by 20 per cent of NHS consultants" (Rivett 1998:297).

Tax Incentives

According to Klein the spread of private medical insurance coverage in the 1980s from 6.4 per cent of the population to 11.5 per cent was not due to any fiscal or other measures by the Conservatives to encourage it, but owed more to a general rise in economic prosperity and disposable incomes. The growth had taken place with little fiscal encouragement. The only specific step, he says, was in respect of employer-provided PMI: "to increase marginally (to £8500) the income limit below which tax concessions could be claimed for health insurance premiums". (Klein 1995:132)

This is not to say that the Conservatives were not interested in incentives for private medical insurance, which had long been a popular cause within the Party and the New Right think tanks. The Adam Smith Institute, for example, had long been demanding tax breaks to boost PMI take-up (Timmins 2001:386). Proposals for tax-relief on private medical insurance for the over-65 year olds were finally included in the 1989 NHS White Paper "Working for Patients"(Dept of Health 1989b). This sat awkwardly within a policy document otherwise aimed at improving the NHS. Analysis on behalf of the House of Commons Health Select Committee described the proposal for tax relief as "*perverse and the worst feature of the White Paper*".(Barr et al. 1989)

In mapping this particular case history using Kingdon's three policy streams of problems, people, and policies it is clear that the Prime Minister plays a very central role. In this case, however, the debate is over a tax policy rather than a social services policy and the approach taken by the Chancellor of the Exchequer is inevitably of central relevance. The Chancellor can be expected to be a veto player whenever fiscal policy decisions are taken, and in this case the Chancellor had held

office, with some success, throughout the Conservatives' second term: By the time of the 1987 General Election the British economy combined strong growth with low inflation(Conservative Party 1987b).

Problem

Even before the 1987 General Election Mrs Thatcher was becoming concerned about policy for the NHS, and had requested radical ideas from both the Department of Health and the Centre for Policy Studies(Timmins 2001:457). But it is not evident that this provided support for her subsequent demands for tax relief for private medical insurance. The NHS crisis over the winter of 1987-88, discussed earlier, provided urgency in the search for reform ideas, and an opportunity for her to raise the idea of tax relief. In her memoirs Thatcher argues that her perception of the problem was that if growth in the private sector continued only at a slow pace this would increase pressure over the long term for additional increases in NHS spending: In the absence of faster growth in the capacity of the private sector, she argued: "all the additional demands would fail to be met by the NHS"(Thatcher 1993:613). Subsidising the private sector would help meet these demands.

People

Margaret Thatcher, Prime Minister

The Prime Minister had a long-standing concern to reward those who sought to look after themselves rather than rely on the state to do so. Furthermore, unlike the Treasury she attached importance to tax subsidies, particularly for the middle classes. Indeed, in August 1979 she engaged in a heated exchange with the then Chancellor, Geoffrey Howe, over his plans to remove tax breaks from company cars as the start of a campaign to reduce the use of "perks" to avoid tax. Thatcher told Howe in a private memorandum to the Treasury that she was "horrified" by his consultation paper on company cars, mainly because of the potential impact on "middle earners" if the company car perks were withdrawn¹⁰⁶.

¹⁰⁶ See Annexe

Nigel Lawson, Chancellor of the Exchequer

"A good tax system should be broadly based, with low tax rates and few tax breaks"

(Lawson 1992:341)

The Chancellor's primary ambition was to reduce the burden of taxation, particularly income tax, which the Conservatives had failed to achieve in their first term. On 19th January 1984 Lawson explained his strategy for personal taxation in a memorandum to the Prime Minister. He was, he said, aiming to pursue a three-stranded approach: (i) to use a shift towards Value-Added Tax¹⁰⁷ to increase the scope for income tax cuts, (ii) to improve incentives, and (iii) to remove or reduce distortions(Lawson 1992:334). According to Harris: "Nigel Lawson was the most successful tax-reforming Chancellor Britain has had"¹⁰⁸(Harris 2011:494)

Lawson knew that the removal of special reliefs would not appeal to Thatcher. He says: "She was constantly proposing new tax breaks of one kind or another, usually arguing that this was preferable to higher public spending" and "in subsequent Budgets was against taking any further moves to reduce fiscal privilege"(Lawson 1992:336).

Willets stresses the importance of the rising tensions between Lawson and Thatcher by 1987, at the time when she was also pressing for tax relief on PMI premiums¹⁰⁹. Tensions began to mount in 1985 over Lawson's wish for Sterling to join the European Exchange Rate Mechanism (ERM). Thatcher was taking informal advice from Alan Walters¹¹⁰ who was vehemently and publicly opposed to the ERM. Lawson raised the topic again after the 1987 General Election and began, without Thatcher's approval, to use interest rate policy to keep Sterling below three Deutschmark (DM3)

¹⁰⁷ A sales tax, which the Conservatives increased significantly in their 1979 Budget.

¹⁰⁸ Harris also notes, however, that Lawson's reputation was eventually destroyed by macroeconomic mismanagement.

¹⁰⁹ Interview: 4 July 2006

¹¹⁰ Professor of Political Economy, Johns Hopkins University, Economic Adviser to the Prime Minister 1981-83. Knighted in 1983. His firm, public advice against Britain joining the ERM in 1988, led to an open dispute between the Prime Minister and her Chancellor. In 1989 he was formally reappointed as Thatcher's economic adviser, prompting the resignations of both Lawson and Walters. The following year Thatcher too was forced to resign Telegraph, 'Obituary: Sir Alan Walters', *Daily Telegraph*, 5th January 2009.

as a precursor to joining the ERM at that rate. The Prime Minister discovered this in November 1987 and the increasingly public dispute continued through the winter. Thatcher herself notes simply that: "In the early months of 1988 my relations with Nigel worsened"(Thatcher 1993:702). Nevertheless, Lawson was still in a strong position following the 1987 election victory, and in the Spring of 1988 delivered a populist tax-cutting budget. At this point the NHS Review was well underway. The Chief Secretary to the Treasury, John Major, also represented the Treasury on the Review, and would have had to steer a very careful course between Lawson and Thatcher¹¹¹.

John Moore, Secretary of State for Health and Social Services 1987-8

Moore was an enthusiast for private health care and for insurance as a solution to the problems of the NHS in 1987-88. Indeed, when he became seriously ill whilst health minister he chose to be treated in a private hospital, for which the Conservative Party Treasurer, who himself used private medicine, described Moore as "a fool" for doing so (Young and Trewin 2009:273). Moore had trained as a banker in America, and was married to an American. His transatlantic, free-market approach appealed to Thatcher. According to Libby, his special adviser, his views on the NHS were heavily influenced by his wife¹¹². At the time the Prime Minister was, according to Edwina Currie, also heavily under American influence, in her case from President Reagan, and both Currie and Libby (Moore's special adviser) attach significance to the transatlantic influences on Thatcher at this time¹¹³.

In 1987 Moore was popular with the Prime Minister. During the election campaign she had decided that he should be given a "higher billing" as a younger face of the party(Thatcher 1993:584); this was soon followed by his appointment to her Cabinet after the election. He was, she said, "a radical, anxious to reform the ossified system he had inherited"(Thatcher 1993:589). At that time, however, housing and education, were set for radical reform, not the health service. According to both

¹¹¹ John Major was promoted to the Cabinet in 1987, as Chief Secretary to the Treasury

¹¹² Interview: 3 June 2009

¹¹³ Interviews: Libby 3 June 2009; Currie 24 May 2012

Willetts and Libby, Thatcher saw Moore as presentable and smooth; able to better present the Government's case on health and social services¹¹⁴.

In early October 1987 Moore and his ministers held a political "thinking day" at Chevening House¹¹⁵, otherwise attended only by Moore's private secretary¹¹⁶ and two members of the Conservative Research Department. In addition to ideas for an NHS internal market, Edwina Currie's diary records that:

"We agreed to seek tax relief on BUPA subscriptions for the over-75s, as they do have to pay extra – doubt if the Chancellor will agree, but worth trying"¹¹⁷.

With the agreement of the entire ministerial team Moore would have been in a strong position to put the case to the Prime Minister, who would anyway be supportive.

Policies

If the "problem" was that growth in the private sector was worryingly slow, and unable to provide a large enough safety valve for health care demands, there appears to be no evidence that this problem was either discussed or evidence gathered on steps to boost private sector growth. As noted earlier, the discussion at this time had already focused on ideas for the separation of purchasers and providers, with little interest in reform of the financing of the health system.

For the very specific issue of slow private sector growth it seems that there was a single policy prescription: A state subsidy to individual insurance subscribers. Thatcher later claimed that "I was not arguing for across the board tax relief for private health insurance premiums – though in principle that would be justified – but rather for a targetted measure. If we could encourage people over sixty to maintain

¹¹⁴ Interviews: Willetts 4 July 2006; Libby 3 June 2009

¹¹⁵ Since 1956 Chevening House in Kent has been maintained by a trust, and its occupancy decided by the Prime Minister. In recent decades it has been occupied mainly by the Foreign Secretary. It is also used for government meetings, notably by Treasury ministers in advance of Budget statements. In 1987 it was occupied by Sir Geoffrey Howe QC MP. Chevening, 'Chevening House', <<http://www.cheveninghouse.com/index.html>>, accessed 12 September 2012..

¹¹⁶ Geoffrey Podger

¹¹⁷ Edwina Currie. Unpublished diary entry for 5th October 1987 (Annexe)

the health insurance which they had subscribed to before their retirement, that would reduce the demand on the NHS from the limited group which put most pressure on its services" (Thatcher 1993:613)

Lawson, however, recalls that during the 1988 NHS Review: "I came under heavy pressure from Margaret [Thatcher], strongly supported by John Moore¹¹⁸, with Roy Griffiths¹¹⁹ voicing his approval, to introduce tax relief for private health care. More precisely, what they wanted to do was to make all subscriptions to BUPA and similar private health insurance schemes tax-deductible, and to cease to tax as a benefit in kind the provision of private health care to employees under a company scheme – a rapidly growing perk". Lawson argued that capacity constraints meant that this would simply increase prices and health sector pay, and was concerned that it would also pave the way for demands for similar concessions for private education(Lawson 1992:617).

Discussion

There is little evidence that tax relief is either efficient or effective within a mixed healthcare system. King and Mossialos found that once PMI relief was removed by Labour in 1997 the rate of withdrawal from coverage amongst the over-60s was not dissimilar to that for all age groups, although they do suggest that the removal of tax relief may thereafter affect the take-up rate amongst new subscribers aged over 60 years(King and Mossialos 2005).

The gradual but consistent growth of the private health sector, including PMI coverage, may have formed part of a more general shift towards a neo-liberal culture and away from an earlier social democratic culture; Harley et al., in a survey of Australian and United Kingdom providers of health insurance find a distinctly "neoliberal discourse" taking place, focusing on individual responsibility for health, and with private health insurers as partners in meeting this responsibility. They

¹¹⁸ Secretary of State, Department of Health and Social Security

¹¹⁹ Sir Roy Griffiths, Deputy Chairman and Managing Director of Sainsburys PLC, author of the 1983 report of the NHS management inquiry Roy Griffiths, 'Nhs Management Inquiry: Report to the Secretary of State for Social Services', (London: Department of Health & Social Services, 1983)., and Deputy Chairman ,NHS Management Board and Health Policy Adviser to the Government 1986-89 Clifford Graham, 'Obituary: Sir Roy Griffiths', *The Independent*, 29 March 1994 1994..

argue that the state is part of this modern discourse, which demonstrates a significant shift away from the social democratic tradition of health provision based on clinical need (Harley et al. 2011). If true, this gives insurance an important role in the wider cultural shift with regard to the welfare state. The presence of tax relief, as a form of state endorsement of private medicine, may have reinforced this cultural shift. Nevertheless, insurance is only one of the ways of paying for private care, and whilst growth in the insurance market levelled off from the end of the 1980s, the number of people paying on a fee-for-service basis experienced strong growth thereafter (Farrington-Douglas and Coelho 2008). From the evidence cited above the debate within the Cabinet over tax relief appears to have included little or no consideration of the private healthcare market, and was conducted purely on the grounds of ideology and Exchequer cost.

Returning to Kingdon's model of policy streams; in the case of PMI tax relief there was not a clear and widely accepted "problem" to combine with the "people" and "policies" required to generate a window of opportunity for change. It seems that the Prime Minister envisaged a *future* problem of excessive demands upon the NHS from rising expectations as well as demographics. She had also, during the 1987 General Election, repeated her strong belief in a "right" to private medicine, and that this amounts to an extra beneficial investment in healthcare. David Willetts recalls discussing this with the Prime Minister: "She said people should have a right to private health insurance. It was just a point of freedom"¹²⁰.

The Department of Health's Chief Economic Adviser, Clive Smee, said that for the Department of Health: "Officials produced the same arguments that they would make about charging. It wasn't the direction that we wanted to go in, plus the fact that it would benefit those who already had insurance. It probably wouldn't encourage any more to take out insurance. I think it was seen as something that was imposed by the Prime Minister ... It was a fairly small concession to a fairly small group of people. It wasn't affecting the great majority of the population"¹²¹. But Keith Mans, then a Conservative Member of Parliament perhaps reflecting

¹²⁰ Interview: 4 July 2006

¹²¹ Interview: 7 June 2006

bankbench opinion, shared Thatcher's view: "if you're trying to reduce the pressure on the NHS in terms of waiting lists, [PMI relief] is an attempt ... to get some partnership with individuals who are able to pay for the care they get ... the fact that you are paying for your care twice is in addition"¹²².

Warwick Lightfoot, a special adviser to Nigel Lawson as Chancellor at the time of the NHS Review recalls that: "there was a feeling that we want to do something bigger, more radical. The big idea was to give *de minimus* insurance relief ... The Treasury opposed that. They simply said that all this would do is give tax relief to people who have already got private insurance, and we would just have a deadweight cost. So the Treasury was very much against it, and also it was a tax expenditure that went against the broader feel in government of a more neutral tax system"¹²³. In fact, Lawson had such a strong commitment to fiscal neutrality¹²⁴ that the Prime Minister described him as "a convinced fiscal purist"(Thatcher 1993:612)

According to Willetts the debate within government over tax relief was more politically charged than it mattered in policy terms, partly because it formed part of a wider battle between the Prime Minister and the Chancellor: "It just became an item on a list of grievances ... What [the Prime Minister] said was that you needed mechanisms whereby you would help people with middle incomes, given sufficient money, to be able to opt out, and obviously tax relief helped to bridge that gap. The big problem was deadweight costs, and the reason we ended up with a compromise of only having it for older people is that not many older people had health insurance"¹²⁵.

The political concerns were that this tax relief might be taken as a demonstration of a limited commitment to the NHS. David Willetts repeatedly tried to convince the Prime Minister of the problems associated with providing tax relief for private medical insurance:

¹²² Interview: 13 April 2006

¹²³ Interview: 27 July 2011

¹²⁴ That the tax system should be simplified and be neutral with regard to behaviour

¹²⁵ Interview: 4 July 2006

"A tax relief option sounds like Tories looking after their own. 'What about me? I'm on a modest income. I can't afford private health insurance. What help is there for me, and what are the Tories going to improve the health service for me?'" Willetts sought to explain to Thatcher: "The reason people are worried about this is not that they don't think they have a right to private health insurance; they think that if you're in favour of people having private health insurance, it shows you don't really care about the NHS, because you think people are going to be able to leave the NHS. What you have to do is to have a sense that you're fixing the car, not that you've got your eyes on a different car. Focus on what you do to improve the NHS rather than have people exit from it."¹²⁶

The tax relief was introduced alongside the NHS internal market reforms from 1990, but in 1994 the Conservatives under their new leader, John Major, restricted the relief to the basic rate of income tax¹²⁷. It was removed completely by the Labour Government in 1997.

With the benefit of hindsight Lawson regrets conceding the tax-break for the over 60s. Within weeks of the decision and whilst the NHS Review was still underway Kenneth Clarke had replaced Moore as the Health minister on the review team, and would not have supported Thatcher's demands (Lawson 1992:617). Clarke has been described as "a true believer in public medicine"(Young 1990:549). Whilst Moore "pushed hard for tax reliefs, which Ken Clarke would not have done ... Ken was a firm believer in state provision", according to the Prime Minister(Thatcher 1993:614).

When Clarke became Chancellor of the Exchequer in 1993 he used his first Budget to restrict tax relief on private medical insurance to the basic rate of income tax¹²⁸. The short experiment with PMI tax relief from 1990 to 1997 provides a demonstration of the power of a Prime Minister who had won three elections in a row. Over time her style had become increasingly presidential, and she seems to have relied as much on

¹²⁶ Interview 4 July 2006

¹²⁷ Higher rate taxpayers had previously been able to claim relief from income tax at their marginal rate of tax.

¹²⁸ Announced in the November 1993 Budget and effective from April 1994

external advice in key areas of policy as on her own ministers and officials. Until July 1988 she also had a brief period when she had a minister responsible for the health service who shared her desire to actively promote private healthcare as an alternative to the NHS. After obtaining the support of the other DHSS ministers at their Chevening House meeting in October 1987, as the NHS winter crisis began, Moore and Thatcher were able to put tax relief onto the agenda for the subsequent NHS Review. It does appear that by October 1987 Moore, and possibly Thatcher, had already agreed that the concession should be for the elderly only¹²⁹, so that the NHS Review simply provided the opportunity to introduce the change amidst a wider debate over health policy.

Between its first financial year of operation in 1990-91 and 1993-4 the costs of the relief doubled to £80 million, but the number of people covered rose by just 10 percent to 550,000 (HD Debates 2 November 1995 c423W). By the time of its abolition in 1997 the Government estimated that the annual cost would be £140 million by 1999-2000 (HC Debates 2 July 1997 c312). A 2001 study by the Institute for Fiscal Studies calculated that, despite the potential increase in demands for NHS care from abolition, the Treasury reaped a net benefit from its removal (Emmerson et al. 2001).

Tax relief for PMI continued to feature in Conservative Party policy after it had been abolished by Labour in 1997, but was eventually omitted from the 2005 manifesto and replaced with proposals for a "Patient Passport" voucher scheme, perhaps in response to rapid growth in the market for self-funding private health care amongst the uninsured. In 2006, after the Conservative Party's third successive election defeat, its new leader set out a very different approach to health policy, saying that: "The right have spent too much time trying to get people out of the NHS and into the private sector" (Cameron 2006). Thus the debate over PMI tax relief was brought to an end 16 years after it had been introduced.

¹²⁹ Currie's notes from the Chevening meeting (Annexe) record that a concession to the over-75s was proposed by Moore. Presumably this was impractical as other taxes and benefits relate to the state retirement age. The reduction to age 60 made the relief much more significant in cost terms.

12. Adult Dentistry

Introduction

The fundamental shift of adult dentistry began shortly after the agreement of a new NHS contract in 1990, when the Government's response to increasing costs prompted a formal dispute with the dentists. This was not settled until 1996, when the new mixed public-private market was acknowledged in a revised contract that would make children's dentistry the NHS priority and pave the way for a purchaser-provider system whereby General Dental Practitioners would contract locally with health authorities to provide specified NHS services. The 1990 contract came at the end of a decade in which NHS charges had increased dramatically, as had potential dental costs due to technical advances and socio-economic progress. This chapter, therefore, charts the path to the 1990 contract, as rising charges culminate in the removal of free dental checks, and dentists begin to opt out of providing NHS adult services. The analysis uses existing secondary material and primary research in interviews to investigate the approach pursued in this lasting boundary shift.

Background

Questions over the place of dentistry within the NHS go back to the origins of the Health Service (Rivett 1998:30). Upon the creation of the NHS in 1948 not only was there a shortage of dentists, but only about half of them joined the new scheme when it started (Timmins 2001:130). Within two years of its creation, the removal of dentistry from NHS coverage was already under serious consideration within the Labour government, and the first recourse to charges was made. The commissioning of the Guillebaud Report in 1953 and the committee's report of 1956 (Ministry of Health, 1956) put an end to such radical retrenchment in the NHS through a convincing demonstration of the financial sustainability of the existing arrangements (Rivett 1998:113).

In 1979 the Royal Commission on the NHS, established under the previous Labour administration, commented that the elements of its work that dealt with dentistry constituted “*the first general review of the NHS dental service in twenty years*” (Ericksen 1990:19). As with so much of health policy, the operation of the NHS General Dental Service (GDS) was not fundamentally affected by the first two terms of Conservative government between the 1979 and 1987 general elections. Indeed, one leading representative of the profession commented that dentistry just “*ticked along*”¹³⁰ for more than a decade, until 1990¹³¹. Policy had focused on limiting the rising costs to the Exchequer by increasing the patient contribution to NHS treatment. Until 1985 this was achieved by gradually increasing the maximum patient payment, largely at a pace that reflected price inflation. But in 1985 patients were faced for the first time with paying not only the first £17 of any treatment cost but also 40 per cent of any costs above this threshold. In 1989 this was changed to 75 per cent of *all* costs (except dentures) and the universal right to free examinations was removed. According to independent estimates this latest policy change represented an immediate increase of 14.8 per cent in the cost actually faced by patients (Health Committee 1993). It had the effect of arresting the rising costs that the NHS was experiencing for the provision of crowns and dentures, albeit with an increase in the fees claimed for extractions (Laing & Buisson 1999:38, Fig 5.1).

In 1986 two dentists created a 'payment plan' system to enable patients to choose private dentistry without the financial concerns associated with a fee-for-service arrangement, and encouraging preventative care. This was called Denplan. By 1988 some 30,000 patients had already enrolled in Denplan, and the provider saw enrolment growth rates averaging 70 per cent per annum over the subsequent five years (Laing and Buisson 1990: 74, Table 7.3). Private dental insurance and payment plans continued to grow rapidly thereafter, peaking at around 50 per cent of revenues in the private dental market in 2006/7 (Denplan 2012; Laing & Buisson 2011).

¹³⁰ Michael Watson, British Dental Association special adviser since 1990, and previously at the General Dental Practitioners Association (GDPA). Interviewed 27 October 2004

¹³¹ *ibid*

In the 1980s dental caries declined dramatically as a result of the increased use of fluoride toothpastes (S. Jones et al. 2005). This meant that the NHS dental contract would need to shift towards preventative care and maintenance and away from a fee-for-service system for removals, fillings, other restorative treatments and the provision of dentures. The incentives within the fee-for-service system were proving to be no longer appropriate, and its adverse effects on dental practice were becoming a cause for concern. In 1986, for example, a Committee of Inquiry published its report into "Unnecessary Dental Treatment" (Schanschieff 1986).

These concerns led eventually to a new NHS General Dental Services (GDS) Contract, agreed between the Department of Health and the British Dental Association in 1990. The new contract introduced monthly capitation payments for the care of children registered with an NHS dentist, in order to shift funding from treatment to prevention, and "continuing care" payments for adult registrations. Following the new contract dentists derived about 20 percent of their income from capitation and continuing care payments rather than treatment (Bloomfield 1992:8).

The policy up to this point had simply been to minimise the cost to the NHS as much as seemed possible by gradually increasing the amount taken in charges. According to Smee, the Department of Health's economic adviser, there was no concerted strategy to shift boundaries, but pressures in negotiations with the Treasury dictated that charges needed to be used:

"Once the resource implications of the things that ministers want to do have been properly worked out, there wasn't enough money to go round to fund things like dentistry ... there are higher priorities ... dental services have fallen out of the public sector in virtually every country in the Western world. I cannot think of a country where adult dental services are not market led. Internal markets have been very popular, but nothing like as universal as private dental services". (Smee 2006)

Willetts, however, stressed that whilst the Conservatives were committed to maintaining NHS dentistry the relative boundary shift that took place in the faster growth of the private sector: *"wasn't completely an accident. There was a conscious*

view that for certain adults it would be legitimate for them to go and pay privately for their dentistry. So there was an alternative route available, and we would expect that route to grow". (Willetts 2006)

Problem

The 1992 "Clawback"

Almost immediately after the 1990 contract was implemented in 1991 it became apparent that dentists were *"doing better than expected"*¹³². The stated intention of the new contract had been to shift the focus of NHS dentistry from treatment to prevention, with the introduction of a system of capitation-based payment as part of the dentists' NHS remuneration.

Table 4 Dental Registrations 1990-92

Impact of Continuing Care & Capitation Payments on NHS patient registrations		
<i>England</i>	Adults	Children
1990-91	10,234,160	3,847,454
1991-92	19,203,525	6,207,294
Source: HC Deb 25 Jun 1992 c302W		

This had led to a notable increase in both registrations and activity, and thus an "overspend" on NHS dentistry. The repercussions of this were set to strain relations between the profession and the Government for the remainder of the Conservative years. The remuneration system relied on

accurately forecasting the amount that would be spent, based on a Target Average Net Income (TANI) per dentist after provision of an allowance for practice expenses. The target and expenses allowance were established by the independent Doctors and Dentists Review Body (DDRB). In the first year of the new contract the overspend amounted to some £12,500 per dentist, or £200 million overall (Dept of Health 1994a:9).

¹³² Interview: Michael Watson, 27 October 2004

The unexpected surge in NHS registrations with General Dental Practitioners, and therefore an unexpected surge in costs to the NHS, led to drastic action by the Government in 1992-1993. In fact, gross payments in 1991-92 exceeded the target by more than 15 per cent (Bloomfield 1992:23). A 7 per cent fee cut was imposed on the profession and more stringent requirements on costly courses of treatment were introduced, so that dentists would need to obtain prior approval from the Dental Practice Board (DPB) for “costly” treatment, with the threshold cut from £600 to £200.

After securing widespread agreement to the 1990 contract, the Government’s actions two years later severely soured its relations with the profession. Robinson et al., have argued that this policy intervention: “gave rise to widespread disillusionment among the profession and to a gradual shift from NHS provision to private work” (Robinson et al. 2004:23). In a British Dental Association ballot of its members following the fee cut, some 60 percent stated that they would be unwilling to accept any new NHS patients whether adult or child registrations, and 80 percent said that they would be unwilling to accept new adult patients (K. Wright 1997b). The Government’s initial response was to attempt to boost the number of salaried dentists employed by health authorities, although it only had 55 such dentists in 1992 (O’Sullivan and Brown 1992).

Throughout the decade from 1992 the number of patients registered with NHS dentists and the number of NHS dentists fell consistently, except that child registrations increased for a time from 1996 (Audit Commission 2002:15). Whereas NHS treatment fees grew by as much as 40 per cent (in real terms) between 1982 and 1988s, funded by increasing NHS patient charges, thereafter they began to fall, and fell by as much as 20 per cent between 1988 and 1994 (Laing & Buisson 1999:46).

In July 1992 alongside the fee cut and tighter prior approval requirements the Minister of State for Health, Dr Brian Mawhinney, had also set up a fundamental review of NHS dentists’ remuneration, led by Sir Kenneth Bloomfield, who had just retired from his post as Head of the Northern Ireland Civil Service¹³³. The review was asked to provide the Minister of Health with specific options for change, and Sir Kenneth determined that any such options should avoid any further “rude shocks” in the relationship

¹³³ Dr Mawhinney was a Northern Ireland Minister from 1988-1992

between the Department of Health and the profession(Bloomfield 1992:23), such as occurred in 1991-92.

The problems of 1991-92 came at a time when dentists operating costs were also rising, thus increasing the attractiveness of pursuing higher fees (and reduced workload) from private practice. The property boom of the late 1980s and high interest rates thereafter will have significantly raised the operating costs of many practices.

The 7 per cent reduction in dentists' fees for the following year (1992-3) that was included in the Government's "clawback" of the overspend played a critical part in damaging its relations with the profession and attitudes to the NHS after both sides had agreed a new contract so shortly beforehand. (Health Committee 2001: para 13)The dentists' reaction to the proposed clawback meant that it did not follow the usual practice of attempting to retrieve the overspend within a single year. Nevertheless, the profession demanded an independent inquiry, as did the DDRB, rather than continue with a system that set a target for an average dentist that did not exist in practice.(Dept of Health 1994a:10)

Lack of NHS dentists

Lack of NHS dentists proved to be a particular problem for the Conservative Party, as it seemed that dentists were most likely to opt out of providing NHS care, particularly for adults, in the most affluent areas due to the local capacity to pay for private treatment. This vulnerability was being exploited by the Liberal Democrats, who campaigned on the abolition of sight tests and dental checks, and the shortage of NHS dentists in these areas of England. The decline of NHS dentistry in the English shires was reflected in significant geographical variations in the financial demands it placed on the NHS: Spending in Cleveland, Greater Manchester, and Merseyside was at least one-third more than in Gloucestershire, Wiltshire, and Oxfordshire(Laing & Buisson 1999:53, Table 5.5). The decline in NHS provision most affected the affluent, semi-rural areas of Britain that were typical political battlegrounds between the Liberal Democrats and the Conservatives. Cornwall was a classic case. The local

Conservative MPs had small majorities over their rivals, mostly Liberal Democrats. In 1992, David Harris the MP for St Ives had a 2.88 per cent majority, Sebastian Coe in Falmouth and Cambourne 5.7 per cent, and Robert Hicks in Cornwall South East 12.8 per cent¹³⁴. Paul Tyler and Matthew Taylor for the Liberal Democrats had won the Cornwall North and Truro parliamentary seats respectively from the Conservatives at the 1992 General Election (Vachars 1993), and maintained the pressure on ministers over NHS dentistry between the 1992 and 1997 elections. The frustration of the remaining Conservatives was very clear. In November 1992 Robert Hicks MP asked Mawhinney:

"Is my hon. Friend aware that over half the dentists in Cornwall are refusing to take new NHS patients? Does he agree that that is both confusing and annoying? When can we expect tangible evidence to correct that unsatisfactory situation and not have to depend on temporary expedients such as the employment of mobile dentistry facilities?" (HC Deb 10 November 1992 c732)

This was the one boundary shift that most adversely affected the Conservatives' own supporters. Edwina Currie has described it as a "disaster"¹³⁵. The former Conservative MP, and aide to the Secretary of State for Health, Virginia Bottomley, Keith Mans, described the situation in dentistry as *"probably ... the most unsatisfactory"* of the areas in which the boundaries of NHS coverage shifted under the Conservatives: *"If you could say that there is a two-tier system, it is in dentistry. There is a big difference between having an NHS dentist and not having one, and that can be purely chance"* (Mans 2006). The irony was that this was a "two tier" NHS in which the better-off fared worst.

The 1992-96 dispute between the dentists and the Government was often blamed for lack of availability of NHS dentists, and until the dispute was resolved the Government could only turn to health authorities to employ salaried dentists as a

¹³⁴ At the 1997 General Election the Conservatives lost Falmouth and Cambourne to Labour, and St Ives to the Liberal Democrats Bryn Morgan, 'Research Paper 01/38: General Election Results 1 May 1997', (London: House of Commons Library, 2001).

¹³⁵ Interview 24 May 2012

means to tackle the problem, but they were few in number and often difficult to recruit. In 1992 the whole of Cornwall was served by just two mobile salaried dentists. (HC Deb 10 November 1992 cc732-3). A poll by the British Dental Association in 1996 found that 35 percent of people claimed it was difficult to find an NHS dentist *"In this survey those living in the South East of England claimed much greater difficulty, with over half of respondents saying it was a problem."*

According to Bottomley, amongst policymakers *"no-one took dentistry seriously"*¹³⁶. It nevertheless proved politically significant as the 1997 General Election approached, primarily because the changing situation in dentistry mostly affected the middle-classes, who faced rising dental costs and loss of NHS provision.

People

For the most part dental policy was left to the Minister of Health, whilst the Secretary of State concentrated on the major issues and crises. Between 1992 and 1997 these included the political battles over the internal market and NHS waiting lists, and discovery of a possible link between bovine BSE and human CJD¹³⁷. The focus here is therefore, on the roles played by the ministers of state responsible for dental policy.

The early stages of the dispute with dentists fell within a time when the Secretary of State for Health was William Waldegrave, and the Minister of State for Health was Virginia Bottomley. Developing policies in response to the dispute, both to deal with the immediate problem and establish a longer-term plan, came after the April 1992 General Election. Waldegrave was replaced by Bottomley as Secretary of State for Health and Dr Brian Mawhinney became Minister of State.

Mawhinney was then replaced in July 1994 by Gerald Malone when John Major conducted a Cabinet reshuffle after Tony Blair became Leader of the Labour Party and the Conservatives' suffered a terrible result in the elections to the European Parliament; they achieved their *"lowest share of the vote since the advent of*

¹³⁶ Interview 20 March 2006

¹³⁷ Bovine Spongiform Encephalopathy and a new variant of Creutzfeldt-Jacob Disease

universal suffrage"(Bale 2010:48) at 28 per cent. A year later John Major resigned as Conservative Party Leader and stood for re-election, in a bid to end the widespread dissent within the Party that was threatening the Government's majority in the House of Commons. Following his re-election he held another reshuffle in which Bottomley, after seven years in the Department of Health, was replaced as Health Secretary by Stephen Dorrell.

Virginia Bottomley,

Bottomley describes ministers as either "*window breakers*" or "*glaziers*", putting herself into the latter category¹³⁸, at least initially in her time as Secretary of State for Health(Bottomley 2006). When appointed she protested to the Prime Minister that she was not yet ready for a Cabinet post (Major 1999:392). After the battle of introducing the internal market as discussed in Chapter 6 her main task was to drive the new system to raise quality. Coming from a public sector background in social work she saw herself as a "*non-executive chairman*" so that "*mostly I forgot I was in politics*" (Bottomley 2006). When she became Secretary of State, she was almost immediately immersed into the political consequences of the Tomlinson Report on the future of London hospitals (Tomlinson 1992), the policy decisions with which she is most often associated and on which she was accused of "*failing to appreciate the politics of the situation*"(Warden 1995). As the internal market began to operate it began to expose the longstanding flaws in the historic pattern of London hospital provision. The Secretary of State, William Waldegrave was able to put off decisions by the creation of the Tomlinson review, to report after the 1992 General Election.

In addition to the problems of decisions over the reconfiguration of London hospitals Bottomley was also responsible for the new Health of the Nation strategy(Dept. of Health. 1992) and the 1991 Patients Charter (Dept. of Health 1991), part of John Major's flagship "Citizens Charter" initiative which, for the first time, set clear standards to be achieved by the public services, backed by new complaints systems. For the NHS this forced the Secretary of State to focus on achieving significant

¹³⁸ i.e. someone who prefers to settle disputes rather than create them

improvements in long waits for elective surgery. Other costly targets included the elimination of mixed-sex wards in NHS hospitals.

Stephen Dorrell

Dorrell returned to the Department of Health in July 1995 with limited experience of NHS primary and secondary care policy, having previously served within the Department (1990-92) as the minister responsible for social services and community care, and no specific prior interest in the topic (Vachers 1993). Recognising the impossibility of fulfilling the "Maples memorandum"¹³⁹ desire to keep the health service out of the news, and to raise his own profile in the Conservative Party¹⁴⁰, Dorrell's mission was to reduce the temperature of the debate, entrench support for the health reforms amongst the professions, and go on the "front foot" against the Labour Party¹⁴¹. Settling disputes with the doctors and dentists was high on the agenda, and professional aspirations were gathered in a "listening exercise" and reflected in two white papers (Dept of Health 1996a, 1996b).

Dorrell largely left the negotiations with the health professions and rapid development of the primary care white paper and subsequent Bill to the Minister for Health, Gerald Malone (HC Deb 11 Feb 1997: Col 149). According to Malone the Secretary of State was preoccupied "*with the big politics of health and persuading the public that we weren't destroying the system, whereas [the Minister] got on with the nuts and bolts of actually delivering change, but change that wouldn't cause a crisis ... we sorted out the dentists, we sorted out the out of hours [dispute with GPs]*" (Malone 2012)

Dr Brian Mawhinney

Mawhinney's reputation as a hard negotiator may well have played a part in John Major's decision to appoint him Transport Secretary at the time of the railway signalmen's pay dispute in 1994. Major knew him very well. At the time of his move

¹³⁹ This is discussed later. It was a Conservative Party internal strategy document that leaked to the press. It argued that the Conservatives should aim to achieve "zero coverage" of the NHS in the media.

¹⁴⁰ The author was special adviser to Stephen Dorrell at this time. His ambitions to succeed John Major after the election were well known.

¹⁴¹ The author was Special Adviser to the Secretary of State at this time

from the Department of Health one colleague predicted: *"He will be very unpopular and make lots of noise in a short time"* (Brown 1994). In the health sector he had earned a reputation for his *"abrasive style"*(Drugscope 1994), which was an attribute in which he took some pride¹⁴². He describes his behaviour as a minister saying: "Even my closest friends say that I do not suffer fools gladly ... some people were hurt or made angry, though that was never my intention"(Mawhinney 1999:164). Mawhinney however, with his background as an academic scientist (in radiology) also worked methodically as a policy broker, and is credited with achieving a policy watershed by transforming the established *"car culture"* of the Department of Transport in 1994-5(Dudley and Richardson 2000:171).

After Major forced and won the leadership election in 1995 in order to face down disloyalty in the Party, Mawhinney was appointed Party Chairman. Major comments: *"Every Prime Minister needs a Party Chairman who is tough as old boots and with a sharp intellect to kick things into shape for them. Brian ... did sterling work as a Downing Street henchman ... he could be brutal with those he thought were wasting his time"*.(Major 1999:694)

The Conservative Party was certainly in great difficulty in 1994. Internal divisions over Europe meant that the Government could not be certain of its majority in the House of Commons, and the Party had reached an historic low point in the opinion polls after Blair's election as Labour leader(Fowler 2008:174). Furthermore, the Party's election analysis was made public when the "Maples¹⁴³ Memorandum" containing focus group findings was leaked to the media. On the health service the memorandum said: *"the Tories' NHS reforms had gone down like a lead balloon and [t]he best result for the next 12 months would be zero media coverage of the National Health Service"* (Bale 2010:50-51). Mawhinney was probably not the right man for this particular job in 1994.

¹⁴² In 1994 the author, then an economist at the Civil Aviation Authority, met with Mawhinney shortly after he joined the Department of Transport in relation to Mawhinney's need to appoint a Special Adviser. One of Mawhinney's demands was the ability to cope with a *"Minister who can make civil servants cry"*.

¹⁴³ The author was John Maples (1943-2012), Deputy Chairman of the Conservative Party.

Gerald Malone

By the time Malone was appointed to the Department of Health he had gained extensive political experience. He was a lawyer, and had been the Conservative candidate in the high profile 1982 Glasgow Hillhead by-election, when the SDP's Roy Jenkins took this previously Conservative seat. As Member of Parliament for Aberdeen South during the second Thatcher term (1983-87) he had been Parliamentary Private Secretary to the Trade and Industry Secretary, Leon Brittan, at the time of the 1985-86 Westland Affair¹⁴⁴, and then a Government Whip.

At the Party Conference in 1987 as a protracted battle was being fought within the Cabinet over whether or not to retain the policy of introducing the Community Charge slowly alongside the system of local rates Malone led calls for an immediate switch. According to Lawson the Prime Minister was impressed, and leant over to the Environment Secretary and said: "*We shall have to look at this again...*" (1992:579). The earlier decision to have a five-year transition period was subsequently reversed.

Outside of Parliament between 1987 and 1992 Malone worked as a journalist at the Sunday Times, and upon his return became Deputy Chairman of the Conservative Party. In contrast to Bottomley, Malone was clearly very much a politician. He was also married to an NHS consultant, so was well-briefed on the health service.

When appointed Minister for Health in 1994 Malone asked the Prime Minister what approach he would like taken to the "bushfires" around the health system, which included the disputes with dentists over pay and the general practitioners over over-of-hours responsibilities: "*Are we in the business of fighting these to the end or do you want me to put them out?*" and was given the answer that "*it would be infinitely preferable to put them out*" (Malone 2012). Thus the search for solutions to the long-term needs of NHS doctors and dentists began in earnest, and Malone managed to

¹⁴⁴ The proposed sale in December 1985 of Britain's only helicopter manufacturer, Westland to the US firm Sikorsky was opposed by the Defence Secretary, Michael Heseltine who sought to find a European alternative.. In January 1986 Leon Brittan leaked a warning letter from the Attorney General to Heseltine, who subsequently resigned, leading also to Brittan's resignation, and questions regarding the Prime Minister's honesty. On the way to an emergency Commons debate on 27th January Thatcher said: "*I may not be Prime Minister by 6pm tonight*". (Hugo Young, *One of Us : A Biography of Margaret Thatcher* (Rev. edn.; London: Pan in association with Macmillan, 1990) xv,589p,(24)p of plates.:431-456)

settle both the GPs dispute over the provision of out-of-hours cover and the dentists dispute that followed the 1990 contract, with a little assistance from the Treasury.

Policies

Bloomfield, the Health Select Committee and the Department of Health all found in their separate discussions with dentists that whilst there was widespread dissatisfaction, there was no consensus on a solution. A survey of dentists by its negotiating body, the General Dental Services Committee, "found divided opinions (with a small balance of opinion in favour) on redefinition of GDS dentistry as a "core service" confined to certain treatments" but positive opposition to the idea of GDS dentistry as a "core service restricted to certain categories of patients"(Bloomfield 1992:60). In fact, the only professional consensus was in dissatisfaction with the current system of remuneration for NHS work.

Similarly, the Government also lacked a plan of its own. Bloomfield said that the Department of Health did not indicate a preference for any specific option, *"Nor did I receive any formal evidence from HM Treasury, although it was very clear to me that it would be unrealistic to think in terms of unlimited resources or open-ended commitments. I should look for a system which would be efficient and cost-effective, and the costs of which would be under proper financial control."* (Bloomfield 1992:64)

Although the Bloomfield Review reported very quickly, it took a further two years before the Government was able to present its proposals(Dept of Health 1994b) for consultation and a further year before final proposals were set out.

In its 1994 Green Paper (Dept of Health 1994a)the Government proposed that dentistry should move to a purchaser-provider system, as now existed for NHS hospital and community health services (HCHS) following the internal market reforms. This, it hoped, would provide a more decentralised system that could better meet variations in local needs than a system based on a national average income. Thus the Target Average Net Income (TANI) would be abolished to be replaced with a system using fixed annual increases in fees proposed by the profession's official pay review body the Doctors and Dentists Remuneration Board (DDRB).Unlike the HCHS internal market,

however, the new purchaser-provider system for dentistry would be piloted before being used more widely.

But the Green Paper also argued that:

"Any reform introduced will need to include some mechanism for dealing with the large sums of money owed by the profession to the Government under the current balancing mechanism."(Dept of Health 1994a:18)

The dentists rejected the Government's proposals, and negotiations to settle the dispute and agree a way forward continued. The Government's *"final proposals"* (Wright 1997a) were set out in April 1995 (HC Deb 5 Apr 1995 cc1211-3W), and an agreement with the profession was announced by Malone on 12th June 1996, less than a year before the latest possible date for a General Election. For the short-term it shifted the focus of NHS dentistry to children's oral health and created a fund to target areas in which there were a lack of dentists providing NHS services. Notably it shortened the registration period for adult continuing care payments, from two years to 15 months; adults who fail to visit a dentist within this shorter time would fall from registration.

The Minister also announced new restrictions on the provision of expensive crowns for back teeth from December 1996. For the longer term there would be legislation to enable pilot schemes of local contracting for NHS dentistry. Notably, in order to end the formal dispute between the Government and the dentists Malone also announced a total waiver of the overpayment now amounting to £16,500 per dentist.(HC Deb 12 Jun 1996, Col 311-312)

Discussion

The 1992 General Election evidently affected the Government's policy responses to the rising cost of NHS dentistry. This came not only at a time of recession, when the Conservatives were not expected, and not themselves expecting, to be re-elected, but also followed the dramatic demise of Mrs Thatcher as the Party's leader, to be replaced by John Major with a strong commitment to the NHS.

Prior to the general election John Major was already struggling with the problem of calming the political battle over the NHS “internal market” reforms, and could ill afford to impose significant cuts in NHS dentistry. It is notable that the most significant increases in the maximum charge faced by patients for NHS treatment were imposed in the post-election years of 1984 and 1988, raising the probability of further cost-containment following the 1992 election. However, it seemed that the situation on charges had reached a limit by the 1990s.

The continual increases during the 1980s in NHS charges to be paid by patients, not only reduced the large differential between NHS and private charges, but also reduced dentists’ own ideological commitment to the NHS by requiring them to seek substantial contributions from their NHS patients. The paperwork associated with the NHS charging regime and the restrictions on dental practice, particularly the need to obtain prior approval for relatively expensive work, also enhanced the attractiveness of private practice.

The problems with access to NHS dentistry, as dentists decided not to take new adult registrations, proved to be most severe in the more affluent areas of southern England, mostly represented in Parliament by Conservative MPs. Although dentists responded to local market conditions and chose to concentrate on private practice in areas where local demand would make this viable, a Conservative government that was ideologically supportive of market-based reform would nonetheless need to take steps to ensure nationwide access to NHS dentistry in response to its MPs’ constituency pressures. In the 1990s these same areas also represented the main target for the Liberal Democrat Party, which naturally adopted the availability of NHS dentistry as a campaigning tool

In the case of dentistry it is unclear whether the use of policy streams to map this particular change is pertinent as it is no easy task to identify a particular window of opportunity for change. The 1990 contract was agreed by the profession. It was the subsequent attempt to claw back the overpayment after a surge in registrations that prompted the long-running dispute and prompted an exodus of dentists from the NHS adult care. The balancing mechanism in the dentists pay system had existed for many

years, but the scale of the mistake in 1991 was unprecedented and even though the Government did not attempt to regain all of the overspend in a single year the 7 per cent fee cut was sufficient to generate a dispute that led to significant changes in the coverage of NHS dentistry.

The net result, however, was an agreement between the Government and the profession in favour of focusing NHS funds on children's dentistry, allied with a political decision to create an access fund for areas with problems of access to NHS dentistry. For the longer term both sides agreed to experiment with a system of local contracting for NHS dentistry, that was incorporated into the Primary Care Act (1997) that also provided for local experimentation in other aspects of primary care. The 1992 claw back may have been a minor act, but with major consequences over a period of years. Thus 1996 was undoubtedly a turning point for NHS dentistry; the private option for adult dentistry had clearly been incorporated into the 1996 contract, whilst a small access fund was deployed to deal with localised problems in affluent areas, and a plan to legislate to enable a localised purchaser-provider system in the future was agreed.

Dentistry does not fit a neat template of a window of opportunity for a change of path. A change was underway and the Government sought to accommodate it rather than stop it. Over time private dentistry grew in value to equal the size of NHS dentistry. If dentistry ever was locked on a path within the NHS, as soon as a more lucrative path emerged many of them took it.

13. Analysis

Research synopsis

In order to investigate the process of United Kingdom health policy change this thesis has brought together data on the origins of the "internal market" reforms announced in 1989 and five case studies of change that began between 1979 and 1997. The selection of this period for analysis, which fell entirely within 18 years of Conservative Party government, allows us to examine a sustained period in which a change in party government does not drive change. It was a period in which there was an underlying predisposition towards welfare state retrenchment.

For the analysis of this period data from the relevant literature was supplemented with interviews with selected individuals from the policy arena at the time. A significant effort was made to ensure a spread of perspectives and roles in the interviewees. This balanced the extensive use of autobiographical material in the research. Interviewees therefore included not only former ministers, but also political and policy advisers, policy academics, and independent policy experts, as well as key civil servants.

The aim was to develop an account that allowed not only for the role that individual personalities in the policy elite might play in incidents of change, using an adaptation of the "politics" stream in Kingdon's model of agenda-setting (Kingdon 1995), but also that took account of influences over policy from the wider political, economic and cultural environment. These were examined in each case.

The research sought an improved understanding of the factors that led over time to the 1989 NHS White Paper "Working for Patients" (Dept of Health 1989b) which set out the internal market policies, and which is often portrayed as a significant change of path for the NHS. Whether or not this was indeed the key point of change remains debatable; it can be argued that a new path had been selected in response to fiscal austerity in 1976 when cash limits were imposed on health authorities for the first time (Thunhurst), or in commissioning the Griffiths Report on NHS management in

1983. This research highlights the fact that change is constant and cumulative, and that the search for a large critical juncture provides a somewhat limited role in policy analysis.

The five case studies cover areas in which there was a notable shift or attempted shift in the boundary between the relative roles of the individual and the state in funding care, in pursuit of policies to limit demands on public spending. These came amidst demographic changes and cultural changes that would otherwise increase these demands. The five cases are heterogeneous in nature, although they are often linked both in time and by associated legislation. In the case of the introduction in 1990 of tax relief on private medical insurance a boundary shift may have been intended, but this did not materialise. This case provides a useful comparison with the other four, as the one which was most clearly driven by political ideology rather than other factors.

The Case Studies

The conceptual framework of the thesis discusses Mahoney and Thalen (2010) depiction of four modes of change and the five case studies provide a useful opportunity to assess how relevant these four modes are to the experience of boundary shifts affecting National Health Service coverage.

It will be recalled that 'displacement' involves the complete or large scale removal of old rules. As Mahoney and Thalen point out, this type of change may be abrupt and radical(2010:15). The 1946 National Health Service Act would be an example. The old local and occupation based approved societies, the national insurance system of contributions and the voluntary hospitals were all essentially swept away. In contrast the steady incremental changes to the contractual basis on which GPs have been employed have added new payment systems and duties but not removed the independent status of GPs or the capitation basis of their funding. This may be thought of as 'layering' as the new rules are laid on top of the old. 'Drift' could be said to have occurred in the treatment of work requirements in the social security system. The neglect of old work search rules grew in the period of high

unemployment in the 1980s and was indeed unofficially encouraged. The return to more rigorous interpretations and elaborations of these rules returned in the late 1990s and subsequently 'conversion' took place as they were implemented in new ways. This is the framework that will now be applied to the case studies.

Ophthalmics

In this case the rules were significantly changed. Since the 1950s the General Optical Council had regulated the profession not only to protect its monopoly in sight testing but also in the supply of spectacles. In a very deliberate step the Government decided to open the market to other retailers of spectacles. In order to meet concerns raised by the Office of Fair Trading and others the Government could have limited the change to this issue, but went further to introduce a voucher scheme to channel NHS funding for the purchase of spectacles. If it had not been for the restriction of rights to NHS spectacles and the removal of free sight tests then the case might have been one of layering, but with these changes then it conforms more closely to the Mahoney and Thelen concept of displacement.

Elderly care

The 1983 change that led to widespread recourse to Supplementary Benefit to fund residential care was additional to the existing regulations for community care. Indeed, changes to the existing regime were not made until after the rapid growth in the private provision of residential care had already taken place, and in response to the way in which this growth had highlighted the inadequacies of the community care system in ensuring the provision of appropriate and efficient care. The experience of community care, therefore, fits best with the description of layering, as a simple new rule was added to the funding of care in 1983. However, it led to a profound long-term change in the public-private balance of finance and provision in this area.

Medicines

A boundary shift in medicines was achieved by two complementary policies. Firstly, the Government sought to make it simpler and faster for a pharmaceutical company to switch a prescription medicine to over-the-counter availability for private purchase in pharmacies. Secondly, the introduction of a Limited List of medicines that would no longer be available on NHS prescription ensured that these products would have to be purchased from pharmacies or obtained by private prescriptions. Switching medicines had always been possible, but with no clear or easy route to do so this was a rare event. In order to introduce controls on what could be prescribed it was essential in terms of supporting the pharmaceutical industry that produced branded medicines to ensure that a viable market existed. Whilst the creation of a process for switching was not "a new rule" inasmuch as it did not change existing policy it was "a new rule" in terms that it made switching a more realistic possibility. No old rules were removed, so the experience of medicines falls clearly within the scope of layering.

Tax relief on private medical insurance

The introduction of tax relief of individually-purchased private medical insurance alongside the internal market reforms of 1990 was a simple concession, requiring just a minor change in tax regulations . Nonetheless it was also significant in conveying strong support for private medicine just at the time when the Government was embarking upon controversial changes to the NHS. Again, this was an instance of layering according to the Mahoney and Thalen model for change.

Dentistry

The rise of private dentistry took place with little initial encouragement from the Government, following the creation of the Denplan scheme. The surge in registrations that followed the agreement of the 1990 contract in response to a remuneration shift towards capitation continuing care, led to a serious and lasting dispute between the Government and dentists that was not settled until 1996. The focal point of the dispute, and the key to its eventual settlement, was the Government's claim to recoup an "overpayment" against a target average income for

dentists. This subsequent loss of faith and morale, combined with a newly viable market in private dentistry, led to a shift towards private care that has never been reversed. The Government, in seeking to claim back the overspend, was using a longstanding balancing mechanism in the remuneration system, albeit to a scale that had not been necessary previously. This process puts the experience of dentistry in the 1990s into the category of a conversion, in which the application of old rules creates a change without the need for new rules.

Discussion

Whilst the Mahoney and Thalen categories provide useful terminology for a moment of change, each case shows a tendency to move between categories over time. In dentistry, for example, change by conversion during the first half of the 1990s created a situation within which new rules were clearly required. The outcome was a new contract that made children's oral health the priority for NHS funding and broadly accepted that adult NHS dentistry should be a safety-net service with a small Access Fund to provide coverage where gaps in the net appeared. Dentistry between 1990 and 1996 underwent a process of change by conversion which in 1996 became a system of displacement. Similarly long-term care of the elderly, whilst initially a process of layering, underwent a more extensive programme of displacement as old rules were removed and replaced in the 1990 NHS and Community Care Act.

Applied to the wider context of health policy a similar picture emerges. The introduction of general management to the NHS might be portrayed as layering, as the new managerial rules applied largely within the existing framework of the NHS, although this cultural change was to play an important part in the changes that would follow. The internal market reforms were a significant political gamble, indeed the Prime Minister came very close to abandoning the reforms at a late stage (Timmins 2001:470). The gamble, however, would probably have been impossible without the earlier introduction of general management. The internal market reforms displaced many of the old rules of British health policy, and established an enduring new model in the ensuing decades, which has seen a

process of incremental *conversion* as the basic rules of the internal market are adapted and extended.

As discussed in Chapter 2 (p28) Mahoney and Thelen categorise the contextual and institutional sources of change according to the degree of discretion in implementation that lies within the institution subject to change and veto possibilities exerted by the political context.

In my assessment above I describe three of the case studies and the Griffiths NHS management reforms as fitting with Mahoney and Thelen's description of layering, which would suggest that this is the most common mode of change in health policy, within which change is produced by the simple addition of new rules rather than by the revised application, neglect or removal of old rules. According to Mahoney and Thelen this mode is typical of an environment within which strong veto opportunities exist. In each of the cases that I put into this category it appears from the evidence that it is the Treasury that carries the most obvious power of veto, as all relate to aspects of care within which spending had become a major concern. The creation of a Limited List of prescribed products that the NHS would no longer fund was somewhat different, it was a change strongly supported, or even inspired, by the Treasury.

Layering and Strong Veto Possibilities

The 1983 change to Supplementary Benefit regulations that produced a growth in recourse to this benefit for private residential care appears to have been the Treasury's preferred course of action in order to meet the serious problems related to long-term care within the NHS and local authority social services. The Government was unlikely to countenance additional resources for local authorities, whose spending it was committed by its 1983 manifesto to control. Using the benefits system to manage the situation had the twin advantages that the Treasury would retain control through its ability to adjust benefit limits, and that the funding would be used to build private sector capacity rather than subsidise local authority provision.

In the case of giving tax relief on private medical insurance it is clear that the Treasury was understandably reluctant, but this policy was clearly a personal demand from the Prime Minister with strong support from John Moore, the Secretary of State for Health and Social Security. It seems that this combination made it impossible for the Chancellor to veto the policy, although he suggests that he would have done so if he had known that Moore would soon be replaced on the NHS review team in 1988 by Kenneth Clarke, who would have also opposed the new tax relief and been willing to argue the case with the Prime Minister. As it was, the Prime Minister was not isolated when the policy decision was taken.

A similar situation arose in the context of the Griffiths NHS management reforms. Griffiths, the Managing Director of Sainsburys, was personally recommended to the Prime Minister by John Sainsbury, and the Permanent Secretary at the Department of Health and Social Security had to make a significant effort to convince Griffiths to take on the task. Whilst in normal circumstances a large and untested investment in management in the public services would face the strong possibility of a Treasury veto, the circumstances involved in the appointment of Griffiths meant that this became highly unlikely once Griffiths had agreed to the project.

The sudden announcement of a Limited List would have had the strong support of the Treasury. The idea of a black list of medicines that would be banned from NHS prescription had existed for many years, but the Government had set itself against such a control. Not only would such a list present a major incursion into clinical freedom, and thus face strong professional opposition from doctors whose independence the Conservatives had fought for in opposing the legislation creating the NHS, but it would also risk damaging Britain industrial success as a base for global pharmaceutical companies. The Government appears to have calculated that doctors would find it difficult to justify a veto of the policy, although they came very close in their strident opposition. They also designed a minimal scheme, that would have little initial effect on the research-based pharmaceutical industry, particularly when combined with new steps to facilitate the switch of medicines from prescription-only status to pharmacy availability. Thus ministers judgement about the power of potential veto holders is crucial.

The low levels of institutional discretion in the interpretation and implementation of changes that Mahoney and Thalen give institutions in cases where change takes place by layering seems pertinent to these cases. Indeed, with regard to the new tax relief on medical insurance and to the use of Supplementary Benefit for private residential care home fees implementation was in the hands of the consumer. The Limited List was imposed by ministers, and although an Advisory Committee on NHS Drugs was established to manage the list, decisions on additions to the list remained with ministers, so that any discretion in its implementation was very low. Although the Griffiths report on the management of the NHS was short, at just 24 pages, it nonetheless established a clear structure for the introduction of general management, with which the NHS had little option but to comply.

Displacement and the general ophthalmic service

The introduction of competition into general ophthalmic services was a dramatic and rapid change. By 1983 the opticians' ban on advertising was at odds with the political context of the country and with developments in the sector. The Office of Fair Trading Report gave ministers the opportunity to act. Alongside the introduction of price competition, by ending the restriction on advertising, the change also presented an opportunity to limit access to NHS-provided spectacles. As would be the case with dentistry, implementation was largely in the hands of consumers, and their demand for higher quality spectacles brought major new entrants into the market. Competition rules and consumer demand meant that the opticians had little realistic capacity to either veto the change or to manage its impact.

Conversion and Dentistry

The privatisation of much adult dentistry from 1990 differs from the other cases as it was, at least initially, driven by dentists and consumers rather than by government. The arrival of Denplan provided a new means of paying for private dentistry, and technical advance, and improving dental health were shifting the focus of adult care. The repercussions of the surge of registrations following the introduction of capitation payments in the 1990 contract, led to cost-control efforts that simply

accelerated the dentists' shift towards private care. In this case, of course, the dentists had considerable discretion in the implementation of the 1990 policy that moved NHS funding partially towards the maintenance of oral health and away from restorative treatment. Their response to the Government's intention to use the usual "balancing mechanism" to claw back the 1990-91 overspend was entirely voluntary. It is notable that the shift towards private care continued after the 1996 settlement of the dispute with the Government, which included the abandonment of the claw back and an overt acceptance that NHS dentistry would be focused on children's oral health.

These cases show the importance of the external environment on exerting veto or directional power, whether this is economic, technological or consumer power. This point will be discussed further at the conclusion of this chapter.

Mapping by policy streams

In order to bring structure to largely narrative accounts the case studies and the history of the internal market were mapped using an adaptation of Kingdon's three policy streams of problems, policies and politics that combine to put an item on the agenda for change in a "policy window". Taking an approach based on the actions of the policy elite I have reduced the politics stream to the individuals involved, described simply as "people". The policy entrepreneurs who, in the Kingdon model, lie in wait for the three streams to converge in order to seize a window of opportunity may often be part of the politics stream themselves. If not, they are unlikely to be in a position to put a policy on the agenda. In my cases, for example, David Willetts plays an important role, both as a policy entrepreneur and as a policymaker. Roy Griffiths was initially simply an external consultant, but became an influential adviser to the Prime Minister and ministers and hence very much part of the politics stream, and it is interesting that in the course of the research his contribution to Government deliberations is evident in many aspects of health policy and not just the management and community care reforms with which he is most associated and in which he played a central role.

This mapping process produces some common observations across the different arenas. The wider economic environment plays a consistently important role in incidents of change. This is unsurprising given the costs to the Exchequer of health and social care, and the relevance to this of any boundary shift that limits future state liabilities for funding. These wider influences do not, however, fit neatly within the three streams, often playing a part not only in the formation of a problem, but also in the policies to address these. This is certainly the case in both dentistry and ophthalmics, where increasing affluence, changing consumer aspirations, and technological improvements created serious problems for the NHS, but were also central elements of policies that would take these services in a new direction. This may be symptomatic of the societal changes brought about by the Conservatives; so that problems of affordability in welfare would no longer be answered with policies to simply control demand, but with wider responses that share demand. As far as the analysis of welfare policy is concerned this significant shift may generate problems for the Kingdon model as it removes the clear division between two of the three streams. This analytical problem is, of course, avoided if problems are narrowly defined, without the inclusion of cultural factors. If, for example, the problem in NHS medicines in the 1980s is simply defined as one of price, and not also of consumerism and self-reliance, then the appropriate policy responses would be similarly narrow and focused on reducing prices, either directly or through generic substitution. A broader definition of the problem, also generates a broader policy response, as seen in most of the cases covered here. Far from restricting demand, the policy responses tend to feed demand. This was the case in elderly care, ophthalmics, dentistry, and medicines.

The “people” stream that has been used as a replacement for Kingdon’s ‘politics’ stream due to a focus on the policy elite in this analysis demonstrates that there may be value in taking such approach, at least in certain contexts, for policy analysis. With funding a routine feature amongst the problems that produce episodes of changes there is a degree of inevitability that Treasury ministers and the Prime Minister, as First Lord of the Treasury, should play a significant role. More interesting is the strategic role played by health ministers, in seeking to obtain the best from this

situation. In particular, it seems that Fowler played a very tactical game in the case of long-term care for the elderly; he achieved a shift to Supplementary Benefit funding for an expansion in private bed capacity, which fell outside of his department's controlled spending limit and onto a demand-led area¹⁴⁵ of social security spending. This supported significant growth in the private sector provision of residential care, making fundamental reform both possible and necessary.

The policies stream produces interesting results. These also raise questions as to how broad this stream might be, as technological change and concepts of quality appear to be important in policy development. Most particularly, looking at these cases it is clear that the development of the state's role as a purchaser of care, and perhaps not the sole provider, pre-dates the NHS internal market that was developed by the Government during 1988. Indeed, the changes in long-term residential care from 1983 and the spectacle vouchers scheme from 1986 show this approach being put into practice.

As discussed above an analysis that is wholly focused on Kingdon's three streams however lacks adequate breadth to capture the environmental factors that can underlie new policies. The rise of a consumer agenda in the 1980s played an important part in the changes that took place in each of the case studies. New possibilities in spectacle frames and lenses, rising expectations in old age, and the rise of cosmetic treatments in dentistry all provide examples of where external factors would also be increasing the opportunities for change. Others who have used the streams approach to map case studies have found similar shortcomings in providing a complete explanation of why policy windows open. An analysis of Professor Darzi's role as a "policy entrepreneur" for changes to London's health system found that although he developed and promoted policies for change, he did not conform to Kingdon's description of a policy entrepreneur, waiting for policies to come along when a political opportunity arises. In the Darzi case there was no policy "readiness", and Darzi himself redefined the problem that he would address (Oborn et al. 2011). Roberts and King subdivide policy entrepreneurs into

¹⁴⁵ Known as Annually Managed Expenditure intended to be reactive to unplanned needs, particularly unemployment

four groups: "political entrepreneurs", "executive entrepreneurs" (leaders in official roles), "bureaucratic entrepreneurs" (others in the official system), and "policy entrepreneurs" outside officialdom (Roberts and King 1991). This research emphasises the role of political entrepreneurs within the selected cases of change. As Willetts remarked on the internal market reforms: "We didn't need Alain Enthoven coming over to develop an internal market model, but having an American expert coming in saying it was better than just having a Policy Unit saying it"¹⁴⁶. Several of the policies studied were very vague when legislated, and the policy entrepreneurs associated with them played an important role in their subsequent development.

The role of clan disloyalty

The research highlights the important role played by a very small number of people within the health policy elite. This is a feature of the health policy arena noted by Kingdon who comments that, even in a country the size of the United States, within this arena: "there is a fair amount of interaction among the admittedly diverse elements" (Kingdon 1995:118).

Additionally, evidence from several cases emphasises the way in which external financial and cultural circumstances drive change. It reveals little to suggest that health policy is subject to self-reinforcing processes that limit the scope for this change, other than a very general resistance to change. In some of the cases the level of institutional resistance is extremely high: In 1987 the Conservatives came close to losing Parliamentary votes on ophthalmic and dental reforms within months of a successful re-election campaign that had produced a parliamentary majority of 102 seats.

The actions of the policy elite and external change alone cannot account for lasting policy change. In the case of tax relief for private medical insurance the change did not persist and spread. Importantly, in four of the five cases, and in the account of the internal market reforms, changes soon became entrenched because there was a small grass-roots movement to support them, sufficiently disloyal to the earlier

¹⁴⁶ Interview 4 July 2006

arrangement. This is very similar to the game-theoretic account given by Greif and Laitin of the divergent histories of Venice and Genoa; in the case of Venice they argue that the "quasi-parameters" within that society suppressed inter-clan rivalry in Venice even after the uniting effects of external threats to the City disappeared, but these factors were not present in Genoa in the same circumstances, so that the latter city's institutions collapsed amidst clan disloyalty. They did not act to bring about a collapse of the old order, but were motivated by the endogenous "quasi-parameters" of the institutional arrangements. In Venice endogenous factors within its complex political system meant that the clans still had an underlying interest in maintaining the old order after the external environment changed. Those involved in both cities may well have failed to understand why they reacted as they did, but they responded to the incentives that were present (Greif and Laitin 2004). A similar effect is seen in the case studies if a change in the external environment enables a sufficient degree of disloyalty within at least one clan, then a policy of institutional change becomes a realistic proposition. Whilst the disloyal actors within the health policy arena may not have perceived themselves as playing a game-changing role, or desired such a role, their responses to external changes, whether by policymakers or amongst their customers, played a significant part in establishing a change of path: Within healthcare, for example, if a sufficient group of doctors or dentists opt-in to new arrangements against the wishes of their representative organisations, as happened in 1948, this may be sufficient for decisive change to become established. Acting upon their own motivations rather than those of policymakers, their disloyalty has a profound effect.

In some areas the external change that leads eventually to disloyalty arises from technical or social change. In ophthalmics, dentistry, long-term care of the elderly, and making medicines available in pharmacies technical change made improved standards of care possible, for which there was a degree of effective demand in the private market. Individual consumers and providers seized the opportunities to act once they were able to do so. Government action to change the parameters of the game followed.

The purchaser-provider separation that was first developed in long-term care of the elderly and later in the NHS internal market became entrenched because there was a sufficient number of eager purchasers to make the new system work. In long-term care this was driven by a new incentive from 1983 that enabled local authorities, as purchasers, to shift costs from their own budgets and onto centrally-funded Supplementary Benefit. In the NHS internal market, the voluntary general practitioner fundholding scheme, saw sufficient numbers of GPs opt in to holding budgets by the time of the election of a Labour government in 1997 to have established both the decentralised purchasing of care in particular, and the internal market more generally¹⁴⁷. In the case of tax relief for private medical insurance, by 1997 there was both an insufficient number of people who would be harmed or complain upon its removal, and an increasing cost to the public purse. The policy to give tax relief on private medical insurance did not provoke disloyalty. Neither the insurance sector nor consumers demonstrated sufficient enthusiasm that this concession could become entrenched and, perhaps, extended.

Set within the context of health policy since the Second World War, and the debate over the creation of the NHS, this research suggests that the path taken has been changed substantially. This has not come about at a critical juncture resulting from an external shock, but by piecemeal, incremental changes most of which took place between 1983 and 1996.

Between the 1944 coalition white paper and Bevan's 1947 NHS Act the debate focused on the independence of hospitals and doctors within the health system, and decentralised administration. The similarities between the Conservatives' ambitions in 1944 and in 2010 are striking (Dept of Health 2010a; Min of Health 1944). The major difference is that in 1944 the Coalition Government argued for local authorities to be responsible for local health services, whereas in 2010 this role would be taken by local "GP commissioning consortia , working in partnership with local authorities" and with local "Health Watch" organisations funded by local authorities.

¹⁴⁷ This conflicts with the political rhetoric of 1997 in which the NHS internal market and GP fundholding were abolished.

This study set out to address three research questions relating to the processes of health policy continuity and change. It has taken a novel approach looking specifically at examples of change which, taken together and over time, challenge assumption of continuity. Through a combination of micro and macro levels of investigation it sheds some light on the factors involved.

Does path dependency adequately explain health policy under Conservative governments?

The most fundamental aspect of the NHS remained unchanged by 18 years of Conservative government motivated by a "New Right" philosophy. In 1997 the NHS could still be described as a comprehensive, universal service largely free at the point of use. This is the same description as could have been applied in 1952 after charges for some services were introduced, if not in 1948 when the NHS was created.

This does not necessarily imply that the NHS experiences the self-reinforcing processes that are central to the existence of path dependency. The changes that took place in the case studies, and in the wider internal market reforms, took place despite strong pressures for the status quo, and arguably the reforms of the 1980s changed the culture of the NHS. Taken together the changes that have occurred amount to a cultural shift that has transformed both the language of discourse on health policy, and redefined the boundaries of state provision.

The fact that the NHS remains largely tax-funded may not be the result of self-reinforcing processes, but the result of a rational calculation that this is the cheapest and most controllable means of ensuring the basic, universal health coverage to which all countries aspire. The debate within Government over the question of tax relief for private medical insurance presented a situation in which this rational concern to control public spending was confronted with a political concern to reward those who assume a degree of personal responsibility for their own health. This is a rational choice rather than a constraint imposed by any self-reinforcing processes. The counterfactual in this case would be that if tax-funding was more expensive than an alternative funding system would the NHS funding system have been retained due to the institutional or other constraints on change associated with it? With the

constant questioning of the NHS, and the dominance of the Treasury in decisionmaking, it seems doubtful that it would.

It is clearly the case that the NHS has been a very economic solution to fulfilling a common ambition. This does, of course, also raise the question as to why other countries have not adopted a tax-funded model. This is particularly pertinent for those countries of Central and Eastern Europe which needed to create new health systems following the collapse of communism after 1989. Tax-funding is not the only means of establishing a single insurance pool in order to avoid the risk-selection problems associated with health insurance schemes, but it is the one that gives the Treasury the most direct control over spending.

Turning to the question of charges for NHS care. Again, as the case studies demonstrate the peripheral role of charges within the NHS owes more to economic logic than to self-reinforcing processes created by the NHS. There are limited aspects of care in which charges could serve a useful role. The risk of deterring early treatment and preventative care, leading to delayed intervention is high. Where charges are unlikely to lead to these effects they have been used. This is particularly true of dentistry, as oral health and technical advances produced a shift from fillings, removals and denture fitting to routine care and cosmetic treatments. Other charges are simply a means of raising money, and a useful tool in spending negotiations within government.

The case studies and the discussion of the internal market demonstrate a very limited role for institutions in processes of change. In most of the cases change occurred despite strong opposition from the main institutions associated with the case. In the case of long-term care of the elderly the initial change was such a small, technical change that it faced no apparent opposition. Indeed, the perverse incentives then in the care system presented widespread intrinsic support given that the change produced an inflow of new finance to a system confronted with excess demand and typified by poor standards of care.

The most significant barriers to change came from within government. The Treasury was a longstanding opponent of tax "perks", but the Prime Minister's concerns to show support for self-reliance amongst people on "middle incomes" and her demands for limited tax relief on private medical insurance in 1988 was too forceful to resist, and too limited to be a serious cause for Treasury concern given the much wider debates between the Chancellor and Prime Minister in 1988. The financial pressure would be the same whatever the core system used for state-funded care. In ophthalmics and dentistry, the personal and constituency interests of Conservative members of parliament made the process of change rather uncertain. Even shortly after a third decisive election victory in 1987, the Conservative rebellions in parliamentary votes over the removal of free sight tests and dental checks reduced the Government's majority to single figures.

Bevan and Robinson take issue with Tuohy's claim that path dependency within the NHS is generated by its state-hierarchical structure, which ensured that pre-existing relationships were maintained across the new purchaser-provider divide in the 1990s(Tuohy 1999b). Instead, they argue that economic logics account for limitations on policymakers in moving the NHS away from the suboptimal balance of cost-control, equity and efficiency generated in 1948(Bevan and Robinson 2005). Neither of these accounts, however, seem to claim that health systems experience increasing returns to a particular path, so that the longer a path is kept the stronger the self-reinforcing effect. Path dependence without increasing returns is not path dependence. That there are strong forces against change is not unusual, but to assert path dependence without a requirement of increasing returns is not a falsifiable theory of continuity. Neither Tuohy nor Bevan and Robinson demonstrate increasing returns if change is avoided.

Furthermore, the evidence of change is substantial. The level of parliamentary opposition to the cases presented, including opposition from Conservatives, does not suggest that the changes would have occurred if a different government, with different leaders, had been in power from 1979. The Royal Commission on the NHS in 1979(HMSO 1979) strongly endorsed the status quo, which would have had a similar effect as the Guillebaud Report(Guillebaud 1956) in limiting the options for

radical change had the Government not possessed a very strong ideological drive for change. All these examples throw more doubt on the path dependency model of health policy that is so dominant in the literature, as discussed in Chapter 2.

What are the common factors in the processes of change?

problems

In reviewing the case studies and the origins of the internal market reforms it is clear that in most cases there was a very clear problem to be addressed.

Change Factors in the Case Studies						
	Internal Market	Ophthalmics	Elderly	Medicines	PMI Relief	Dentistry
Problems	Financial Crisis	Competition, Spending Cuts	Capacity, Poor Care	Spending cuts, Consumerism	Perceived Inequity	Industrial Dispute, NHS access
People	Lawson, Thatcher, Moore, Willetts	Fowler, Knight	Fowler, Griffiths	Fowler, Marks	Thatcher, Moore, Lawson	Mawhinney, Malone
Policies	Purchaser-Provider	Liberalisation, Vouchers	Purchaser-Provider	Limited List, POM-P Switch	Relief	Child health focus, Purchaser-Provider
Other	Consumer-focus	Technical change	Rising wealth	Industrial Policy	Ideology	Technical change

Table 5 Factors in the Case Studies

The exception was tax relief for private medical insurance. Whilst the Prime Minister may have felt that it was unfair that some people were "paying twice" for

healthcare, with no recognition, this was by no means a pressing political problem. The take-up of private health insurance had grown rapidly from the late 1970s, and although the rate of growth was slowing by the time of the 1988 Ministerial Review of the NHS, growth continued nonetheless. Two specific arguments were made by ministers in support of a tax relief solely for the elderly; that these people had previously enjoyed private insurance under employer-provided schemes, which they would lose on retirement; and that they would fall back on the NHS at the stage in life when their care needs would be rising, which was the source of most pressure on the NHS. These, however, were arguments made by ministers in support of the policy change, rather than problems that were in the policy arena before the change. This lack of a clear "problem" may well account for the fact that this change was reversed in 1997.

people

In each case there was at least one person within the policy arena whose actions ensured that change occurred. Ironically, in the case of the Limited List for medicines and the internal market reforms it seems that the Chairman of the British Medical Association (BMA) may have played a role in ensuring that the changes were completed. The political structures of the BMA mean that it is prone to very strong reactions to policy, given the level of internal competition between its leading figures. This may be a longstanding issue for the BMA, as the account of the creation of the NHS reveals a similarly extreme reaction to Bevan's proposals, with the Conservative Party giving its support to the BMA even after the Bill had received Royal Assent. Contrary to some accounts of health policy, this research suggests not only that the BMA and other interest groups are unable to block change, but also that they can in certain cases actually reinforce change. In the case of the 1988 review that led to the internal market reforms a high profile intervention by the medical royal colleges appears to have been an important factor in convincing the Prime Minister of the need for a fundamental review as they demanded (Edwards and Fall 2005:65).

Policies

The case studies demonstrate a weakness in Kingdon's depiction of the policy stream in agenda-setting. It was actually rarely the case that there were well prepared policies, with their own policy entrepreneurs lying in wait, at the initiation of change. In the case of the Limited List it seems that a policy for generic substitution was better prepared and more widely advocated than one for a limited list of prescribable medicines. Similarly, in the funding of long-term care of the elderly, this had been debated for many years with no obvious solution when ministers took steps to boost private sector residential capacity. In the case of ophthalmics the initial step of lifting the sector's self-imposed ban on optician advertising was a small step with significant consequences, that did not require policy entrepreneurs to press a case. The privatisation process of adult dentistry was well underway by the time the Government and the profession developed a bilateral policy response in 1996. Even then, the residual problem of access to NHS dentistry was to be addressed by local contracting, which would be developed in pilot projects following the 1996 Primary Care Act. This was by no means a well-developed policy waiting for problems and politics to present its opportunity to join the agenda. These instances required an astute politician with some political vision to see an opening and to pursue it.

Environmental change

A common theme throughout the cases is the shift towards a system that is more consumer-focused, whether through a separation of purchasers and providers, so that purchasers take on an agency relationship, or through the direct empowerment of users through enhanced choices or voucher schemes.

Issues of technical and cultural change play a prominent role. The Griffiths management reforms introduced new functions to the NHS, including information technology systems, without which the internal market would have been a technical impossibility. The advent of fluoride toothpaste and, to a very limited extent, water fluoridation, made a shift in the role of dentists inevitable, indeed the remuneration

system failed to keep pace with the improvements in oral health seen during the 1980s.

It can be argued that technical advances combined with a new focus on public spending restraint from 1976 lay behind each of the changes discussed in this paper. Pharmaceutical advance, for example, has been significant in increasing life-expectancy, particularly in the context of cardiovascular disease, with improving treatment of hypertension and blood lipid levels. As the blockbuster medicines produced by the pharmaceutical industry since the 1960s began to go off patent, a system would be required both to provide the developers with an ongoing income stream and to ensure the use of generic versions within the tax-funded health system.

Cultural changes during the 1980s were dramatic, and one of the lasting memories of the Thatcher years. The health system was not exempt from the rise of consumerism. In 1972 Geoffrey Howe was appointed to Heath's Cabinet as the first Minister for Consumer Affairs and told the National Council for Social Services that they should see their clients as "essentially no different in their needs and desires, in terms of service, from the customers of shops and garages"(Howe 1994:71). This was a sentiment that was not to be fully pursued for some time.

How can theory better explain the NHS policy process?

This research has focused on change rather than continuity in health policy, and by doing so it has revealed the rational processes that may lie behind a change of direction. The substantive changes that have been studied, whilst they demonstrate distinctive changes of path, have taken place in a systematic way outside of events that would qualify as critical junctures. In economic terms they better reflect the common processes of incremental innovation in which old technologies experience diminishing or constant returns, than processes of path dependency with increasing returns and requiring a substantial external shock to generate a shift from a sub-optimal technology. Harrison & Wood's theory that there has been a recent change from health policy reforms based on a developed "blueprint", as in the 1974 NHS reorganisation, to reforms around a basic "bright idea" (S. Harrison and Wood 1999)

is challenged by the most recent reforms set out by the Conservative-Liberal Democrat Coalition government in 2010, with a new administrative model for the NHS. This conformed much more to the model of a blueprint than a bright idea, and suggests that Harrison's attempt to explain the 21st century policy process as different to what went before does not offer a robust basis for analysis, at least at the health system level, although reforms by occasional "bright ideas" might be said to feature in some of the case studies discussed: GP budgets might be a good example.

Mahoney and Thalen's four modes of change, however, does appear to provide a flexible model for analysis and assists in developing a theory of policy continuity and change. The inclusion of strong and weak veto possibilities appears to fit well with the data from the case studies in this research.

Theory of the policy process must, however, incorporate the role of change in the external environment. The Conservatives used these changes in a strategic way to create a new base of support that often confounded the opposition to reform. According to Clive Smee, in the early years of the Conservative governments from 1979 civil servants in the DHSS were resistant to the Conservative policies and were, therefore, sidelined by ministers because "they seemed unable to move with the times"¹⁴⁸.

Clan disloyalty

The cases covered in this paper show the importance in policy change of a cohort of actors who prove disloyal to the old regime. Their disloyalty may be shaped by the

¹⁴⁸ Interview: 7 June 2006. Smee adds that this contrasted significantly with the situation in 1997: "I think civil servants were much more conscious of the fact when Blair came in ...political advisers" (interview) and later added: "this understates the contrast between the Department's reaction to Blair and to Thatcher. In 1996 I was sent on a three month round the world tour by my Perm Sec in large part to collect ideas that might interest an incoming Labour Government. Several ideas in the first Labour Government White Paper, "The New NHS, Modern, Dependable" came directly out of that tour, including NHS Direct and regular patient experience surveys. (Blair's memoirs say NHS Direct was invented by Robert Hill, his health political adviser, but it was not. The title and the idea came from one of my senior Operational Research colleagues - I still have the minute in which the idea was first put forward.)" Email 14 Sept 2012

obscure "quasi parameters" of the game in which they are actors, or incorporated into reformers' policy design. The most obvious example is that of fundholding general practitioners in the internal market. Whilst Tuohy describes resilience within the internal market due to the persistence of past relationships between purchasers and providers, it was the fundholding experiment that broke these relationships sufficiently to entrench the purchaser-provider model in the NHS. The fundholding scheme only took off because of the enthusiastic involvement of the pioneering GPs who took it up in its first year despite the vigorous opposition of the BMA. The Secretary of State for Health, Kenneth Clarke, claims to have invented the concept of fundholding whilst on holiday in Galicia(Ham 2000:7). Whilst ideas for GP budgets had been in the policy arena over the preceding few years (Teeling-Smith 1984) and advocated by one particular civil servant who had himself been a GP(Glennerster and Lieberman 2011). It was undoubtedly Clarke who introduced this into the ministerial review of the NHS in 1988 after his summer holiday (Timmins 2001:462).

The level of clan disloyalty when the NHS reforms were introduced in 1990 appears to have been greater than ministers anticipated. The earlier Griffiths reforms had created a new group of managers who were not tied to the old system, and the fundholding scheme presented new opportunities for some GPs. But with regard to the latter Clarke says; "the object was to get them going and then make them the envy of the service". The internal market began with 57 hospitals opting for independent "Trust" status and some 1700 GPs in fundholding practices(Timmins 2001:467-9). Ophthalmic liberalisation from 1983 created new opportunities for an increasingly-wealthy population to shop around for designer spectacles and sunglasses. The introduction in 1986 of a voucher scheme extended this privilege to those who still qualified for NHS support, and they opted in rapidly increasing number to top-up their vouchers in order to trade-up in spectacles. At the same time companies including Boots (a pharmacy) seized the new opportunities to enter the opticians market. These breaks from loyalty to the status quo that had persisted within the ophthalmic service since the 1950s mitigated the effects of changes to the NHS charging regime and shifted the culture of the market for ophthalmic services. Similar processes were witnessed in long-term care of the elderly, dentistry and

medicines. The clans of providers and consumers who were content to break with the old system made the changes viable and sustainable.

Contemporary application

In each of the cases where boundaries shifted and lasting change emerged the new approach addressed a specific problem. In 1983 there was clearly frustrated demand in the market for spectacles that NHS funding would be unable to satisfy and a shortage of capacity in the market for care of the elderly, and worrying growth in the NHS drugs bill. In 1987 the health system was gripped by a financial crisis that had not be averted by constant growth in spending. In the 1990s dentists were opting out of adult NHS care creating gaps in NHS coverage.

Hecló in an historical analysis of the failed Clinton health reforms identifies the lack of a clearly defined and conveyed purpose as an important factor in the proposals' failure (Hecló 1995). This may also, of course, be relevant to recent efforts at reform. The Coalition government's 2010 blueprint for health reform had a poorly-defined purpose, and when its Bill was published they "struggled to explain the logic" (Timmins 2012:84) particularly as the preceding message to the electorate from both parties in the coalition was that structural reform was not required. Launching his 2010 White Paper the Health Secretary claimed that: "*People voted for change*"(Dept of Health 2010b) and told Parliament that:

"The NHS today faces great challenges: it must respond to the demands of an increasing and ageing population, advances in medical technology and rising expectations; it remains stifled by a culture of top-down bureaucracy, which blocks the creativity and innovation of its staff; and it does not deliver outcomes in line with the best health services internationally-many of our survival rates for disease are worse than those of our neighbours. The NHS must be equipped to meet those challenges. We believe it can do much better for patients, so today I am publishing the White Paper, "Equity and Excellence: Liberating the NHS", so that we can put patients right at the heart of decisions made about their care, put clinicians in the driving seat on

decisions about services, and focus the NHS on delivering health outcomes that are comparable with, or even better than, those of our international neighbours." (HC Deb, 12 Jul 2010, Vol. 513, Col 661)

His statement appeared to include eight or more purposes for the reforms, with no particular focus. By being confusing, however, it was also (initially) also less controversial than it became. For all the debate that ensued later, just one Liberal Democrat, John Pugh, intervened during the discussion of the Ministerial statement on the White Paper, and then only to question the degree of direct local accountability within the new system. The opposition came from outside the House of Commons. In November 2010 the leadership of the Royal College of GPs changed, and a new hostile approach to the plans was launched (Timmins 2012:71).

The Health Secretary appears to have decided to present the reforms as revolutionary rather than an evolution of what Labour had done since 2001, in order to avoid giving any credit to his political opponents. In the context of a coalition government this seems to have been a mistake. Lansley lacked the foot soldiers of change that were present in other reforms. It was unclear who would benefit. The contrast with the case studies in this research is clear. In each successful case of change there would be a group who ready to defend the new regime by their actions whilst the major institutions were still fighting over the old regime.

The relevance of a role for disloyal clans in policy change can be seen in these most recent reform measures. As well as a lack of clarity over the problem to be addressed by the 2010 health proposals it was also unclear who might benefit from them: The commissioning of care was to be devolved to "GP commissioning consortia", involving not only GPs, but local authorities and others. This is unlikely to be an attractive proposition for either. Managers would lose their posts in Primary Care Trusts and Strategic Health Authorities, with the abolition of these agencies. All hospitals would be forced into independent operation as "Foundation Trusts" subject to market forces within a health system facing unprecedented financial constraints. Users of the service were told simply that the changes would somehow

meet the challenges of demographic change. The possibilities for a disloyal clan to play a part in entrenching the changes was very limited.

In contrast to this, education policies were being simultaneously pursued that were following the GP fundholding approach of encouraging bottom-up support for change. This was despite professional and political hostility. In September 2011, less than 18 months after taking office the Conservative-Liberal Democrat coalition government had already established the first "Free Schools". The change had evidently elicited a disloyal clan and set out a clear purpose within a new agenda of "localism".

14. Conclusions

This research questions the value of models based on path dependency for the analysis of welfare reform. The case studies of change demonstrate no evidence of the increasing returns that would be accrued if a change of path is avoided. Indeed, the changes that took place appear if anything to have been partly in response to decreasing returns from the existing path, whether measured financially or in political capital.

Following Krasner's branching model (Krasner 1984), in each of the case studies policy made a decisive turn onto a new branch, and when taken together these appear to have also slowly pulled the overall health system in the new direction within a cultural shift for healthcare. In most of these cases the individuals involved within the policy elite played a crucial role. Within the internal market reforms, for example, the replacement of Kenneth Clarke for John Moore made a dramatic difference, not because Clarke was more trusted on health policy, but because he understood the tactics required to defeat the British Medical Association having faced them over the Limited List five years earlier. Clarke indirectly enlisted a disloyal clan of GPs and managers to support the change. The research demonstrates that the presence of potential disloyalty to the established pattern of service and professional leadership amongst those affected by change can be a crucial factor in the process.

The research demonstrates the value of setting social policy within its wider context in order to understand the process of change and the quasi-parameters that might be at work in the policy arena. Whilst some of these might be visible, which would include the electoral cycle, others in the socio-economic environment may be less so. The rise of a consumer culture, which formed a core part of Thatcherism, played an important part in many policy arenas, becoming a new parameter for policy making and affecting actors' responses.

Whilst Kingdon's policy streams provide a useful template for mapping episodes of change, the three streams struggle to allow for the important role played by cultural

and technical change in agenda setting, unless a broad definition of problems and politics is used, which then generates overlap and confusion between these streams. Excessive focus on the micro-picture in a streams-based analysis can lead to the neglect of the effects of changes at the macro level. Whilst the confluence of the three streams at a point in time provides a robust explanation of change in many cases, it appears not to do so in every case. To stretch Kingdon's metaphor a stage further, the streams may converge, but their banks may also be on the move. These larger forces may, if anything, have the greater effect on agenda setting.

Originality

The research uses a novel design to investigate health policy under the Conservatives between 1979 and 1997, combining the traditional literature with grey material, particularly biographical material, and a small number of interviews to investigate change. The researcher's own role within the policy arena enabled the identification of several interviewees whose influence and role would be relatively unknown. Indeed, some had never before been interviewed on the subject. These interviews provided valuable insights into the policy process at crucial points for the research.

Drawing on explanations of endogenous change based in game theory (Greif and Laitin 2004) the research identifies a critical role for clan disloyalty in achieving a change of direction. These agents of change might be both unwitting with regard to their role and unprepared, but are able to seize new opportunities when endogenous features of the "old" system give little disincentive against this. It is the challenge for the policymaker to identify the potential for clan disloyalty and act when this potential can be realised.

Research Limitations and Proposals for Future Research

The concept of clan disloyalty as a factor for change within the policy process requires further investigation. It is unclear from this research whether policymakers were aware of the potential for such disloyalty in advance of each change, or whether the emergence of clan disloyalty was simply a fortuitous outcome. The case

studies do not reveal evidence of any prior analysis, for example, of the potential for new entrants into the markets for spectacles, dentistry, or residential care, or how many GPs might have been willing to take up the opportunity to hold their own budget. Some degree of estimation of clan disloyalty should be possible, but it is as yet unknown whether this was intrinsic to the policymaking process and the decision to embark on a change of direction. Further research into the case studies using a game theoretic approach, and the motivations of those who displayed disloyalty to the status quo may reveal new insights into the processes of change. Additionally, it would be worthwhile pursuing a similar approach in other policy arenas, to investigate whether branching occurs, in which a small change is used to produce substantive change over time.

References

References

- ABDO (2008) *Our response to the Conservative Party document on top-up payments* [online text], ABDO <**Error! Hyperlink reference not valid.**>
- Abel-Smith, Brian and Titmuss, Richard Morris (1956), *The cost of the national health service in England and Wales* (National Institute of Economic and Social Research Occasional papers,; Cambridge Eng.: University Press) xx, 176 p.
- Abraham, John (2009), 'Partial Progress: Governing the Pharmaceutical Industry and the NHS, 1948-2008', *Journal of Health Politics, Policy and Law*, 34 (6), 931-77.
- Altenstetter, Christa and Busse, Reinhard (2005), 'Health care reform in Germany: patchwork change within established governance structures', *Journal of Health Politics, Policy and Law*, 30 (1-2), 121-42.
- Arthur, W. Brian (1989), 'Competing Technologies, Increasing Returns, and Lock-In by Historical Events', *The Economic Journal*, 99 (394), 116-31.
- Audit Commission (1986), *Making a reality of community care : a report by the Audit Commission* (London: HMSO).
- Audit Commission (1997), *The coming of age : improving care services for older people* (London: Audit Commission).
- Audit Commission (2002), *Dentistry : primary dental care services in England and Wales* (London: Audit Commission).
- Bacon, Robert and Eltis, W. A. (1976), *Britain's economic problem : too few producers* (London: Macmillan).
- Bale, Tim (2010), *The Conservative Party : from Thatcher to Cameron* (Cambridge: Polity).
- Balen, Malcolm (1994), *Kenneth Clarke* (London: Fourth Estate) ix,302p.,[16]p. of plates.
- Barr, N. A. (1987), *The economics of the welfare state* (London: Weidenfeld and Nicholson) xiv, 475 p.
- Barr, N. A., Glennerster, Howard, and Le Grand, Julian (1989), *Working for patients ? : the right approach* (Welfare State Programme; London: Welfare State Programme: Suntory and Toyota International Centres for Economics and Related Disciplines..) 19 p.
- Baumol, William J., Panzar, John C., and Willig, Robert D. (1982), *Contestable markets and the theory of industry structure* (New York: Harcourt Brace Jovanovich) xxix,510p.
- BBC (2002), 'That was then: Sir Freddie Laker', 2012 (26 September). <<http://news.bbc.co.uk/1/hi/uk/2283244.stm>>, accessed 17 September 2012.
- Behr, Edward (1991), *'Kiss the hand you cannot bite' : the rise and fall of the Ceausescus* (London: Penguin, 1992).
- Berg, Bruce L. and Lune, Howard (2012), *Qualitative research methods for the social sciences* (8th edn.; Boston: Pearson) xvi, 432 p.
- Berridge, Virginia (2002), 'Poor health : social inequality before and after the Black report', *Contemporary British History*, 16 (3), 131-72.
- Bevan, Gwyn and Robinson, Ray (2005), 'The Interplay between Economic and Political Logics: Path Dependency in Health Care in England', *Journal of Health Politics, Policy and Law*, 30 (1-2), 53 - 78
- Blackstone, Tessa and Plowden, William (1988), *Inside the Think Tank : advising the Cabinet 1971-1983* (London: Heinemann).
- Blenkinsopp, Alison and Bradley, Colin (1996), 'Patients, society, and the increase in self-medication', *British Medical Journal*, 312, 629-32.

- Bloomfield, K. (1992), *Fundamental review of dental remuneration* (Great Britain, Department of Health).
- Bloor, Karen and Maynard, Alan (1993), *Expenditure on the NHS during and after the Thatcher Years : its growth and utilisation* (University of York, Centre for Health Economics).
- BMJ (1992), 'NHS Withdrawing From Care Of Elderly, Says King's Fund', *BMJ: British Medical Journal*, 305 (6851), 442.
- Bosanquet, Nicholas (1983), *After the New Right* (London: Heinemann).
- Bosanquet, Nicholas (1985a), *Public expenditure on the NHS, recent trends and the outlook* ([London]: [Institute of Health Services Management]).
- Bosanquet, Nick (1985b), 'Public Expenditure Rules and the NHS', in University of York Centre for Health Economics (ed.), (Discussion Paper No 3; York).
- Bottomley, Virginia (2006), 'Interview: 20 March 2006', (London: House of Lords).
- Brackenbury, Henry B. (1934), 'Health Insurance in England', *The Milbank Memorial Fund Quarterly*, 12 (3), 194-202.
- Bridges A (2000), 'Path dependence, sequence, history theory', *Studies in American Political Development*, 14 (Spring), 109-12.
- Brittan, Samuel (1988), *A restatement of economic liberalism* (2nd ed. edn.; Basingstoke: Macmillan).
- Brown, Colin (1994), 'Cabinet Reshuffle: Pragmatist for transport job', *The Independent*, 24 July.
- Burchardt, Tania (1997), 'Boundaries between public and private welfare: A typology and map of services', (London: Centre for the Analysis of Social Exclusion).
- Butt, Ronald (1977), 'How I plan to govern', *Sunday Times*, 8 May 1977.
- Cabinet (1975), 'Conclusions of a Meeting of the Cabinet', in Cabinet Office (ed.), (London: National Archives).
- (1976), 'IMF Agreement: Memorandum by the Chancellor of the Exchequer. 22 November 1976', in Cabinet Office (ed.), (London: National Archives).
- (1978), 'Expenditure on the National Health Service: Memorandum by the Secretary of State for the Home Department. 2 March 1978', in Cabinet Office (ed.), (London: National Archives).
- (1979), 'Review of Expenditure Programmes during the period in Opposition: Chief Secretary, Treasury: 22 May 1979', in Cabinet Office (ed.), (National Archives).
- (1981), 'Economic Strategy: Cabinet Conclusions: 17 June 1981', in Cabinet Office (ed.), (London: National Archives).
- Cairney, Paul (2012), 'Public administration in an age of austerity': positive lessons from policy studies', *Public Policy and Administration*, 27 (3), 230-47.
- Callaghan, James (1987), *Time and chance* (London: Collins).
- Cameron, David (2012), 'Speech: Improving our NHS', <http://www.conservatives.com/News/Speeches/2006/01/Cameron_Improving_our_NHS.aspx>, accessed 11 September.
- Campbell, John (1987), *Nye Bevan: A Biography* (2nd edn.; London: Hodder & Stoughton).
- Castle, Barbara (1990), *The Castle diaries, 1964-1976* (London: Papermac).
- Chevening (2012), 'Chevening House', <<http://www.cheveninghouse.com/index.html>>, accessed 12 September.
- Chew, Robert C. (1986), *Health expenditure in the UK* (Studies of current health problems.; London: Office of Health Economics) 32 p.
- Clark, Alan (1997), *The Tories : conservatives and the nation state 1922-1997* (London: Weidenfeld and Nicolson) 493p.
- Clark, Greg, Hockley, Tony, and Smedley, Iain (1995), 'The Insurance of Medical Risks', in ABI (ed.), *Risk, Insurance, and Welfare* (London: Association of British Insurers).
- Cloke, Paul J. (1992), *Policy and change in Thatcher's Britain* (Pergamon).

- Cockerell, Michael (1988), *Live from number 10 : the inside story of Prime Ministers and television* (London: Faber).
- Cockett, Richard (1994), *Thinking the unthinkable : think-tanks and the economic counter-revolution 1931-1983* (London: HarperCollins).
- Cohen MMJ & Olsen, J (1972), 'A garbage can model of organizational choice', *Administrative Science Quarterly*, 17 (March), 1-25.
- Collard, David A (1968), 'The New Right: A Critique', in Fabian Society. (ed.), (Fabian Tract No.387; London).
- Conservative Party (1951), *The manifesto of the Conservative and Unionist Party, General Election, 1951* (London: Conservative and Unionist Party) 7p.
- Conservative Party (2012), 'Selsdon Park Mtg, Afternoon session transcript, 31 Jan 1970', <<http://www.margaretthatcher.org/document/109513>>, accessed 8 September.
- Conservative Party (1976), *The right approach : a statement of Conservative aims* (London: Conservative Central Office).
- Conservative Party (1978), *The Campaign Guide: Supplement 1978* (London).
- Conservative Party (1979), *Conservative Manifesto 1979* (London: Conservative Central Office).
- Conservative Party (2012), 'General Election Press Conference Transcript: 4th June 1987', <<http://www.margaretthatcher.org/speeches/displaydocument.asp?docid=106866>>, accessed 2 September 2012.
- Conservative Party (1987b), *The next moves forward : the Conservative manifesto 1987* (London: Conservative Central Office) 77p.
- Cosgrave, Patrick (1996), 'Obituary: Lord Fraser of Kilmorack', *Independent*, 4 July 1996.
- CPU 'Setting patients free [electronic resource] : a Conservative policy consultation'.
- Cranz, Hubertus (1999), 'Switching in Europe', *Drug Information Journal*, 33, 569-76.
- CRD (2012), 'The Way Ahead', <<http://www.margaretthatcher.org/archive/1981cac3.asp>>, accessed 8 September.
- Crewe, Ivor and King, Anthony (1995), *SDP : the birth, life and death of the Social Democratic Party* (Oxford: Oxford University Press) 611p.
- Crisp, Nigel (2002), 'Chief Executive's Report to NHS', in Department of Health (ed.), (London: HMSO).
- Crouch C, Farrell H (2002), 'Breaking the path of institutional development? Alternatives to the new determinism', in Max-Planck-Institut für Gesellschaftsforschung (ed.), *MPIfG Discussion Paper 02/5*.
- Culyer, A, McLachlan, G, and Maynard, A (1982), *The public/private mix for health : the relevance and effects of change; essays* (London: Nuffield Provincial Hospitals Trust) x,565p.
- Culyer, AJ and Birch, S (1985), 'Caring for the Elderly: A European Perspective on Today and Tomorrow', *Journal of Health Politics, Policy and Law*, 10 (3), 469-87.
- Currie, Edwina (2002), *Diaries 1987-1992* (London: Little Brown) 334p.
- Davies, Stephen (2004), *The benefits from competition : some illustrative UK cases* (Great Britain: DTI).
- Day, Patricia and Klein, Rudolf (1985), 'Maintaining standards in the independent sector of health care', *British Medical Journal*, 290, 1020-22.
- Day, Patricia and Klein, Rudolf (1989), 'The Politics of Modernization: Britain's National Health Service in the 1980s', *The Milbank Quarterly*, 67 (1), 1-34.
- Denplan (2012), 'Denplan - About Us - Company History', <<http://www.denplan.co.uk/about-us/about-denplan/denplan-timeline.aspx>>, accessed 7 September.

- Dept of Health (1989a), *Working for patients* (Cm 555; London: H.M.S.O.).
- Dept of Health (1989b), 'Working for patients : the Health Service caring for the 1990s', (London: H.M.S.O.), 8 v.
- Dept of Health (1989c), *Caring for people : community care in the next decade and beyond. Cm 849* (HMSO).
- Dept of Health (1992), 'The National Health Service (General Medical Services) Regulations 1992', in Department of Health (ed.), (London: HMSO).
- Dept of Health (1994a), *Improving NHS dentistry : presented to Parliament by the Secretary of State for Health by command of Her Majesty July 1994* (HMSO).
- Dept of Health (1994b), *Improving NHS dentistry : a summary* (Great Britain, Department of Health).
- Dept of Health (1995), *NHS responsibilities for meeting continuing health care needs* (Great Britain, Department of Health).
- Dept of Health (1996a), *Choice and opportunity : primary care; the future* (Great Britain, Department of Health).
- Dept of Health (1996b), *The National Health Service : a service with ambitions* (Stationery Office).
- Dept of Health (2003), *Building on the best : choice, responsiveness and equity in the NHS* (Cm 6079; London: Stationery Office) 71 p.
- Dept of Health (2006), 'Practice-Based Commissioning: Practical Implementation', in Department of Health (ed.), (London).
- Dept of Health (2010a), 'Equity and excellence: Liberating the NHS', in Department of Health (ed.), (Cm 7881; London: TSO).
- Dept of Health (2012), 'Press Release: Equity and Excellence: Liberating the NHS', <http://collections.europarchive.org/tna/20110720072732/http://dh.gov.uk/en/MediaCentre/Pressreleases/DH_117360>, accessed 3 September 2012.
- Dept. of Health (1991), *The patient's charter* ([London]: Department of Health).
- Dept. of Health. (1992), *The health of the nation : a strategy for health in England : presented to Parliament by the Secretary of State for Health by command of Her Majesty, July 1992* (Repr. 1993 with corrections. edn., Cm; London: H.M.S.O.) 125 p.
- DHSS (1981a), *Growing older (Cmnd 8173)* (London: H.M.S.O.).
- (1981b), *Care in action : a handbook of policies and priorities for the health and personal social services in England* (London: HMSO).
- (1983a), 'Supplementary Benefit (Requirements) Regulations 1983 (Maximum amounts for boarders)', in DHSS (ed.), (SI 1983/1399; London).
- (1983b), *Report to the Secretary of State for Social Services of the Informal Working Group on Effective Prescribing* (London).
- (1985a), *Reform of social security (Cm 9517)* (London: HMSO).
- (1985b), 'Reform of Social Security (Cm 9691)', in Department of Health & Social Security (ed.), (London: HMSO).
- (1986a), *Report of the Committee of Inquiry into an Outbreak of Food Poisoning at Stanley Royd Hospital* (London: H.M.S.O.).
- (1986b), *Primary health care : an agenda for discussion : presented to Parliament by the Secretaries of State for Social Services, Wales, Northern Ireland, and Scotland by command of Her Majesty April 1986* (London: HMSO).
- (1986c), 'NHS Financing: DHSS' response to Bosanquet Report', *British Medical Journal*, 262, 503.
- (1987a), *Public support for residential care : report of a Joint Central and Local Government Working Party (Firth Report)* (DHSS).
- (1987b), *Promoting better health : the Government's programme for improving primary health care* (London: H.M.S.O.).
- Downs, Anthony (1957), *An economic theory of democracy* (New York: Harper & Row) x, 310 p.

- Drugscope (1994), 'Hardliner joins Home Office as Mawhinney leaves health', *Druglink*, September/October.
- Dudley, G. F. and Richardson, J. J. (2000), *Why does policy change? : lessons from British transport policy, 1945-99* (London: Routledge).
- Economist (1982), 'Thatcher's think-tank takes aim at the welfare state'.
- Edwards, Brian C. B. E. and Fall, Margaret (2005), *The executive years of the NHS : the England account 1985-2003* (Oxford: Radcliffe) viii, 219 p.
- Emmerson, Carl, Frayne, Christine, and Goodman, Alissa (2001), 'Should private medical insurance be subsidised?', in Institute for Fiscal Studies (ed.), (London: The Kings Fund).
- Enthoven, Alain C. (1985), *Reflections on the management of the National Health Service : an American looks at incentives to efficiency in health services management in the UK* (Occasional papers / Nuffield Provincial Hospitals Trust ; 5; London: Nuffield Provincial Hospitals Trust) vii, 51p.
- Ericksen, V (1990), 'Professionalism and public policy variations: The case of dental care in Britain and Norway', (University of Bergen).
- Esping-Andersen, Gøsta (1990), *The three worlds of welfare capitalism* (Cambridge: Polity) 248p.
- Etzioni, A (1967), 'Mixed scanning: A third approach to decision making', *Public Administration Review*, 27.
- Farrington-Douglas, Joe and Coelho, Miguel Castro (2008) *Private Spending on Healthcare* [online text], IPPR <http://www.ippr.org/images/media/files/publication/2011/05/private_spending_on_healthcare_1646.pdf>
- Ferrarotti, Franco (1990), *Time, memory, and society* (New York: Greenwood Press).
- Finlayson A, Atkins J 'Leader's Speech, Blackpool, 1976', <<http://www.britishpoliticalspeech.org/speech-archive.htm?speech=174>>, accessed 15 August 2012.
- Foubister, Thomas, et al. (2006), *Private Medical Insurance in the United Kingdom*, ed. European Observatory on Health Systems and Policies (Copenhagen: World Health Organisation).
- Fowler, Norman (1991), *Ministers decide : a personal memoir of the Thatcher years* (London: Chapman's) 372p.
- Fowler, Norman (2008), *A political suicide : the Conservatives' voyage into the wilderness* (London: Politico's) x, 238 p., [8] p. of plates.
- Friedman, L. A., et al. (1974), 'Bacterial plaque disclosure survey', *J Periodontol*, 45 (6), 439-43.
- Friedman, Milton (1962), *Capitalism and freedom* (Chicago: University of Chicago Press) 202 p.
- Friedman, Milton (1976), 'Inflation and Unemployment: Nobel Memorial Lecture', in University of Chicago (ed.).
- Fulop, Christina and Warren, Kevin (1993), 'Deregulation and its Impact on the Opticians' Market: A Comparison of the forecasts of Both Proponents and Opponents with Events in Practice', *International Journal of Advertising*, 12 (3), 257-78.
- Garnett, M (2010), 'New Right', in M Bevir (ed.), *Encyclopedia of Political Theory* (Thousand Oaks: SAGE Publications, Inc.), 971-3.
- Garrett, Geoffrey & Lange, Peter (1995), 'Internationalization, institutions, and political change', *International Organization*, 49 (4), 627-55.
- Gerring, John (2007), *Case study research : principles and practices* (Cambridge: Cambridge University Press).
- Giaimo, Susan (2002), *Markets and medicine : the politics of health care reform in Britain, Germany, and the United States* (Ann Arbor, Mich.: University of Michigan Press ; Wantage : University Presses Marketing).

- Glassner, Barry and Berg, Bruce (1980), 'How Jews Avoid Alcohol Problems', *American Sociological Review*, 45 (4), 647-64.
- Glennerster, Howard (1995), *British social policy since 1945* (Making contemporary Britain; Oxford ; Cambridge, Mass: Blackwell) 275p.
- Glennerster, Howard (2000), *British social policy since 1945* (2nd ed. edn.; Malden, MA: Blackwell Publishers).
- Glennerster, Howard (2007), *British social policy : 1945 to the present* (3rd edn., Making contemporary Britain series; Malden, MA ; Oxford: Blackwell Pub.) xi, 321 p.
- Glennerster, Howard (2009), *Understanding the finance of welfare : what welfare costs and how to pay for it* (2nd edn.; Bristol: Policy Press) xvii, 245 p.
- Glennerster, Howard and Le Grand, Julian (1994), *The development of quasi-markets in welfare provision* (Suntory-Toyota International Centre for Economics and Related Disciplines).
- Glennerster, Howard and Lieberman, Robert (2011), 'Hidden convergence: Towards a historical comparison of US and UK health policy', *Journal of Health Politics, Policy and Law*, 36 (1), 5-31.
- Goldsmith, Michael (2009), 'Interview: 6th May 2009', (London).
- Goodin, Robert E. and Klingemann, Hans Dieter (1996), *A new handbook of political science* (Oxford: Oxford University Press) 845.
- Gorsky, Martin (2010), 'The Griffiths NHS Management Inquiry: Its origins, nature and impact', *Witness Seminar 11 November 2008* (London: London School of Hygiene and Tropical Medicine).
- Gorsky, Martin, Mohan, John, and Powell, Martin (2002), 'The Financial Health of Voluntary Hospitals in Interwar Britain', *The Economic History Review*, 55 (3), 533-57.
- Graham, Clifford (1994), 'Obituary: Sir Roy Griffiths', *The Independent*, 29 March 1994.
- Greif, A and Laitin, D (2004), 'A theory of endogenous institutional change', *American Political Science Review*, 98 (4), 633-52.
- Griffin, LJ (1993), 'Narrative Event Structure-Analysis, and Causal Interpretation in Historical Sociology', *American Journal of Sociology*, 98 (5), 1094-133.
- Griffiths, Roy (1983), 'NHS Management Inquiry: Report to the Secretary of State for Social Services', (London: Department of Health & Social Services).
- Griffiths, Roy (1988), *Community care : agenda for action : a report to the Secretary of State for Social Services* (London: HMSO).
- Guillebaud, C. W. (1956), *Report of the Committee of enquiry into the cost of the National health service. Presented to Parliament by the Minister of health and the Secretary of State for Scotland (Cm 9663)* ([S.I.]: H.M.S.O.).
- Hacker, J (1998), 'the historical logic of national health insurance: Structure and sequence in the development of British, Canadian and US medical policy', *Studies in American Political Development*, 12 (Spring), 57-130.
- Hailey, Gary (1980), *State restrictions on vision care providers : the effects on consumers (201CEyeglasses II/201D)* ([Washington, D.C.]: The Bureau).
- Hall, Peter A. and Taylor, Rosemary C. R. (1996), 'Political science and the three new institutionalisms', *Political Studies*, XLIV, 936-57.
- Ham, Christopher (1999), *Health policy in Britain : the politics of organisation of the National Health Service* (4th edn., Public policy and politics; Basingstoke: Macmillan) 237.
- Ham, Christopher (2000), *The politics of NHS reform 1988-97 : metaphor or reality?* (London: King's Fund) xii, 78 p.
- Hansard (9 February 1948), 'Parliamentary Debates', in House of Commons (ed.).
- Harley, Kirsten, et al. (2011), 'Constructing health consumers: Private health insurance discourses in Australia and the United Kingdom', *Health Sociology Review*, 20 (3), 306-20.

- Harris, Robin (2011), *The Conservatives : a history* (London: Bantam).
- Harrison, Michael (2004), *Implementing change in health systems : market reforms in the United Kingdom, Sweden, and the Netherlands* (London: SAGE) viii, 241 p.
- Harrison, S and Wood, B (1999), 'Designing Health Service Reorganisation in the UK 1968 to 1998; from blueprint to bright idea and "manipulated emergence"', *Public Administration*, 77 (4), 751-68.
- Hayek, Friedrich A. von (1944), *The Road to Serfdom* (London: G. Routledge & Sons).
- Hayhoe, Barney (1986), 'Minister responds to professions' attack on NHS financing', *British Medical Journal*, 292, 426.
- HC Deb 'Hansard'.
- Healey, Denis (1989), *The time of my life* (London: Michael Joseph) 607p.
- Healey, Dennis (1976), 'Letter to the International Monetary Fund 15 December 1976', in HM Treasury (ed.), (London).
- Health Committee (1993), 'Fourth Report - Dental Services', in House of Commons Select Committee on Health (ed.), (London: HMSO).
- Health Committee (2001), 'First Report: Access to NHS Dentistry', in Health Select Committee (ed.), (London: HMSO).
- Health Insurance (2009), 'PMI: The six-week plan', *Health Insurance & Protection*. <<http://www.hi-mag.com/health-insurance/product-area/international-pmi/article364155.ece>>, accessed 12 September 2012.
- Heath, Iona (1994), 'The creeping privatisation of NHS prescribing', *British Medical Journal*, 309 (29 September), 623-4. <<http://ukpmc.ac.uk/backend/ptpmcrender.cgi?accid=PMC2541518&blobtype=pdf>>, accessed 29 September 2010.
- Hecllo, Hugh (1995), 'The Clinton health plan: Historical perspective', *Health Affairs*, 14 (1), 86-98.
- Hennessy, Peter and Seldon, Anthony *Ruling performance : British governments from Attlee to Thatcher* (Oxford : Basil Blackwell, 1987 (1989 [printing])).
- Higgins, Joan (2004), 'Incrementalism in UK policymaking on privatisation in health care', in Hans Maarse (ed.), *Privatisation in European Health Care: A Comparative Analysis in Eight Countries* (Maarsse: Elsevier gezondheidszorg).
- Hill, Michael and Ham, Christopher (1997), *The policy process in the modern state* (3rd edn.; London: Prentice Hall) xi, 254.
- HMSO (1979), *Report of the Royal Commission on the NHS 1979. Cm7615* ([S.I.]: [s.n.]).
- Hockley, T. C. (2007), 'Abandoning the UK NHS?', *Disease Management & Health Outcomes*, 15 (3), 133-34.
- Hoffenberg, R; Todd, IP; Pinker, G (1987), 'Statement by the Presidents of the RCP, RCS and RCOG: Crisis in the National Health Service', *British Medical Journal*, 295, 1505.
- Hogan, John (2006), 'Remoulding the critical junctures approach', *Canadian Journal of Political Science*, 39 (3), 657-78.
- Hogg, Quintin (1947), *The Case for Conservatism* (West Drayton: Penguin Books).
- Horowitz, C. R., et al. (2000), 'Approaches to eliminating sociocultural disparities in health', *Health Care Financ Rev*, 21 (4), 57-74.
- Hoskyns, John (1978), 'The Stepping Stones Programme'. <www.margarethatcher.org/document/109848>, accessed 20 August 2012.
- Howe, Geoffrey (1969), *Report of the Committee of Inquiry into Allegations of Ill-treatment of Patients and other irregularities at the Ely Hospital, Cardiff. (Cm 3975)* (London).
- Howe, Geoffrey (1994), *Conflict of loyalty* (London: Macmillan).

- Howe, Geoffrey and Biffen, John (1980) *CAB129/208 C80(9) Public Expenditure: Memorandum to the Prime Minister 29 January 1980* [online text], Thatcher Foundation Archive
<<http://www.margaretthatcher.org/document/0BD1C0FB2B054B6B85D793AAFE40A443.pdf>>
- HSC (1994), *Health Service Commissioner : second report for session 1993-94 : failure to provide long term NHS care for a brain-damaged patient* (London: HMSO).
- Immergut, Ellen M. (1992), *Health politics : interests and institutions in Western Europe* (Cambridge studies in comparative politics; Cambridge: Cambridge University Press) xxii, 336 p.
- Inland Revenue (1997), 'Press Notice: Tax relief for private medical insurance to be ended', in Inland Revenue (ed.), (London).
- Int Lab Rev (1924), 'Reports and Enquiries: National Health Insurance in England from 1918 to 1923', *International Labour Review*, (9), 587-600.
- Isom, Matthew and Kandiah, Michael D (2002), 'The Origins and Establishment of the Internal Market in the NHS: Witness Seminar 3 July 2000', (London: Institute of Contemporary British History).
- ITN (2012), 'Hole in Heart Baby', <<http://www.itnsource.com/shotlist/ITN/1987/11/25/T25118702/>>, accessed 2 September 2012.
- Jencks, Christopher (1972), *Inequality; a reassessment of the effect of family and schooling in America* (New York,: Basic Books) xii, 399 p.
- Jenkin, Patrick (2002), 'Dispelling the Myths of the Black Report: A memoir', *Contemporary British History*, 16 (3), 123-30.
- Jenkins, Simon (2006), *Thatcher and sons : a revolution in three acts* (London: Allen Lane).
- Jones, Harriet 'The Conservative Party and the welfare state 1942-1955. [electronic resource]'.
 Jones, Harriet (1992b), 'The Conservative Party and the Welfare State', (LSE).
- Jones, Sheila, et al. (2005), 'The effective use of fluorides in public health', *Bulletin of the World Health Organisation*, 83 (9), 670-76.
<<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2626340/pdf/16211158.pdf>>, accessed 23 September 2012.
- Joseph, Keith (2012), 'Speech at Upminster', <<http://www.margaretthatcher.org/document/110604>>, accessed 15 August 2012.
- Jovchelovich, S & Bauer, M (2000), 'Narrative Interviewing', in & Bauer M Gaskell G (ed.), *Qualitative researching with text, image and sound* (London: Sage), 57-74.
- Kahneman, P;Knetsch, JL;Thaler,RT (1990), 'Experimental Tests of the Endowment Effect and the Coase Theorem', *Journal of Political Economics*, 98 (6), 1325-48.
- Kendall, Jeremy (2000), 'The mainstreaming of the third sector into public policy in England in the late 1990s: whys and wherefores', *Policy & Politics*, 28 (4), 541-62.
- King, D. and Mossialos, E. (2005), 'The determinants of private medical insurance prevalence in England, 1997-2000', *Health Serv Res*, 40 (1), 195-212.
- Kingdon, John W. (1995), *Agendas, alternatives, and public policies* (2nd edn.; New York: HarperCollins College Publishers) xiv, 253.
- Klein, Rudolf (1995), *The new politics of the National Health Service* (4th edn.; London: Prentice Hall) 245.
- Klein, Rudolf (2001), *The new politics of the National Health Service* (4th ed. edn.; Harlow: Prentice Hall).

- Knight, Jill (1995), *About the House : a Parliamentarian's commentary* (London: Churchill Press) 215p.
- Krasner, SD (1984), 'Approaches to the State: Alternative Conceptions and Historical Dynamics', *Comparative Politics*, 16 (2), 223-46.
- Labour Party (1964), *Let's go with Labour for the new Britain : the Labour Party's manifesto for the 1964 general election* (London: Labour Party) 24p.
- Laing and Buisson (1990), *Care of elderly people market survey* (4th ed. edn.: Laing & Buisson).
- Laing & Buisson (1989), *Laing and Buisson (1989), Care of Elderly People Market Survey 1989/90* (London: Laing & Buisson).
- Laing & Buisson (1999), *UK Dental Care: Market Sector Report 1999* (London: Laing & Buisson).
- Laing & Buisson (2012), 'Press Notice: The NHS Bites Back at Private Dentistry', <<http://www.denplan.co.uk/about-us/about-denplan/denplan-timeline.aspx>>, accessed 7 September.
- Laing, William (1985), 'Private Health Care', in Office of Health Economics (ed.), (London).
- Lankester, Tim (1980) *PREM19/165 f155 Memo to the Prime Minister: Prescription Charges* [online text], Thatcher Foundation Archive <<http://www.margaretthatcher.org/document/16798DF879E24CCCB219AC409DBF0A75.pdf>>
- Lapsley, Irvine and Llewellyn, Sue (1992), 'Government policy and the changing market in residential care for the elderly: A financial analysis of the private sector', *Financial Accountability & Management*, 8(2), Summer 1992, 0267-4424 \$2.50, 82 (2), 97-113.
- Law, Richard Kidston Right Hon Baron Coleraine (1950), *Return from Utopia* (London: Faber & Faber).
- Lawson, Nigel (1992), *The view from No. 11 : memoirs of a Tory radical* (London ; New York: Bantam Press).
- Layton-Henry, Zig (1980), *Conservative Party politics* (London: Macmillan).
- Le Grand, Julian (1991), 'Quasi-Markets and Social Policy', *The Economic Journal*, 101 (408), 1256-67.
- Le Grand, Julian and Estrin, Saul (1989), *Market socialism* (Oxford: Clarendon).
- Le Grand, Julian, Mays, Nicholas, and Mulligan, Jo-Ann (1998), *Learning from the NHS internal market* (London: King's Fund) xi, 196 p.
- Lindblom, C (1959), 'The science of muddling through', *Public Administration Review*, 19, 79-88.
- Lindblom, Charles E and Woodhouse, Edward J (1993), *The policy-making process* (3rd edn., Prentice-Hall foundations of modern political science series; Englewood Cliffs, N.J.: Prentice Hall) ix, 164.
- Little, Daniel (1996), 'Causal Explanation in the Social Sciences', *The Southern Journal of Philosophy*, 34 (S1), 31-56.
- Macfarlane, Fraser; Exworthy, Mark; Willmott, Micky (2012), 'The 1983 Griffiths Inquiry', in Mark; Peckham Exworthy, Stephen; Powell, Martin; Hann, Alison (ed.), *Shaping Health Policy: Case Study Methods and Analysis* (Bristol: The Policy Press), 348.
- Mahoney, James and Thelen, Kathleen Ann (2010), *Explaining institutional change : ambiguity, agency, and power* (Cambridge: Cambridge University Press).
- Major, John (1999), *John Major : the autobiography* (London: HarperCollins) xv, 774.
- Malone, Gerald (2012), 'Interview: 15 June 2012', (London).
- Mans, Keith (2006), 'Interview: 13 April 2006', (London: Royal Aeronautical Society).
- Marks, John (1984) *The Guardian*, 18 December, sec. Letters to the Editor.
- Marks, John (2008), *The NHS - beginning, middle and end? : the autobiography of Dr John Marks* (Oxford: Radcliffe Publishing Ltd) x, 279 p.

- Mawhinney, Brian (1999), *In the firing line : politics, faith, power and forgiveness* (London: HarperCollins).
- Maynard, Alan and Bosanquet, Nicholas (1986), *Public expenditure on the NHS : recent trends and future problems* (London: Institute of Health Services Management).
- McQueen (Undated), 'Panorama: The Thatcher Interviews and the NHS'. <<http://www.nosuch-research.co.uk/pdfs/Paper%20Panorama.pdf>>, accessed 14 September 2010.
- Miller, Eric John and Gwynne, Geraldine V. (1972), *A life apart: a pilot study of residential institutions for the physically handicapped and the young chronic sick* (London: Tavistock Publications).
- Min of Health (1944), 'A National Health Service', in Ministry of Health. (ed.), (Cmd 6502 London: HMSO).
- Ministry of Health. (1956), *Report of the Committee of Inquiry into the cost of the National Health Service. Cm9663* (Cmd; London: HMSO) xii, 309 p.
- Mitchell, J. Clyde (1983), 'Case and situation analysis', *Sociological Review*, 31 (2), 187-211.
- Mohan, John (1995), *A National Health Service? : the restructuring of health care in Britain since 1979* (Basingstoke: Macmillan) xx,286p.
- Morgan, Bryn (2001) *Research Paper 01/38: General Election Results 1 May 1997* [online text], House of Commons Library <www.parliament.uk/commons/lib/research/rp2001/rp01-038.pdf>
- Mossialos, Elias and Thomson, Sarah MSc (2004), *Voluntary health insurance in the European Union* (Brussels: European Observatory on Health Systems and Policies).
- Murray, Charles (1984), *Losing ground : American social policy, 1950-1980* (Basic Books).
- NAO (1993), 'Income generation in the NHS', in National Audit Office (ed.), (London: HMSO).
- Nelson, Valerie J (2009), 'Robert Gumbiner dies at 85', *Los Angeles Times*, 23 January.
- O'Grady, John (1999), *Medicines, medical devices and the law* (London: Greenwich Medical Media).
- O'Sullivan, Jack] and Brown, Colin (1992), 'Talks raise hopes in dentists' pay dispute', *The Independent*, 1 July.
- Oborn, Eivor, Barrett, Michael, and Exworthy, Mark (2011), 'POLICY ENTREPRENEURSHIP IN THE DEVELOPMENT OF PUBLIC SECTOR STRATEGY: THE CASE OF LONDON HEALTH REFORM', *Public Administration*, 89 (2), 325-44.
- OFT (1982), *Opticians and competition : a report by the Director General of Fair Trading on Sections 21 and 25 of the Opticians Act 1958* (London: H.M.S.O.).
- (2009), *Government in markets : why competition matters - a guide for policy makers* ([London]: Office of Fair Trading).
- OHE (1980) *Effects of Prescription Charges* [online text], Office of Health Economics <http://ohematerials.org/publication_pdfs/Effects_of_Prescription_Charges_1_980.pdf>
- (2012), 'Health Statistics: Expenditure Data', <<http://www.ohe.org/page/health-statistics/access-the-data/expenditure/data.cfm>>, accessed 16 September.
- Osborne, David and Gaebler, Ted (1993), *Reinventing government : how the entrepreneurial spirit is transforming the public sector* (New York, NY: Plume) xxii, 405 p.
- Owen, David (1981), *Fourth Hoover Address : delivered at the University of Strathclyde, Glasgow* ([Glasgow] ([George St., Glasgow G1 1XW]): University of Strathclyde).

- Owen, David (1986), *A United Kingdom* (Harmondsworth: Penguin).
- Owen, David (1991), *Time to declare* (London: Michael Joseph) viii,822 ,[32] of plates.
- Owens, Patricia and Glennerster, Howard (1990), *Nursing in conflict* (Macmillan Education) xi,183p (pbk).
- PAC (1984), *29th Report from the Committee of Public Accounts: Dispensing of Drugs in the National Health Service* (H.M. Stationery Office).
- PAGB (2012a) *POM-P Switches: Updated List 26 April 2012* [online text], <<http://www.pagb.co.uk/regulatory/pdfs/pomtoplist.pdf>>
- (2012b) *Annual Review 2012: Securing our future health* [online text], PAGB <<http://www.pagb.co.uk/publications/pdfs/annualreview2012.pdf>>
- Parliament (1972), *National Health Service reorganisation: England* (London).
- Payne, Ian W (1978), 'General Ophthalmic Services - A practical alternative', *British Medical Journal*, 6153 (2).
- Pearson, M and Wistow, G (1995), 'The boundary between health and social care', *British Medical Journal*, 311 (6999), 208-9.
- Peet, John (1987), *Healthy competition : how to improve the NHS* (London: Centre for Policy Studies).
- Perlman, Mark (1974), *The economics of health and medical care : proceedings of a conference held by the International Economic Association at Tokyo* (London: Macmillan).
- Peters, B. Guy, Jon, Pierre, and King, Desmond S. (2005), 'The Politics of Path Dependency: Political Conflict in Historical Institutionalism', *The Journal of Politics*, 67 (4), 1275-300.
- Phillips, Kevin *The emerging Republican majority [by] Kevin P. Phillips* (New Rochelle).
- Pierson, Paul (2000), 'Increasing Returns, Path Dependence and the Study of Politics', *American Political Science Review*, 94 (No 2 June), 251-67.
- Pierson, Paul (2001) *The new politics of the welfare state* [online text], Oxford University Press <<https://shibboleth2sp.sams.oup.com/Shibboleth.sso/Login?entityID=https://lse.ac.uk/idp&target=https://shibboleth2sp.sams.oup.com/shib?dest=http://www.oxfordscholarship.com/SHIBBOLETH?dest=http://dx.doi.org/10.1093/0198297564.001.0001>>
- Pierson, Paul (2004), *Politics in time : history, institutions, and social analysis* (Princeton, N.J. ; Oxford: Princeton University Press).
- Pinker, Robert A. (1992), 'Making sense of the mixed economy of welfare', *Social Policy and Administration*, 26 (4), 273-84.
- Powell, J. Enoch editor, Maude, Angus Edmund Upton editor, and Carr, L. R. (1954), *Change is our ally* ([S.l.]: [s.n.]).
- Prayle, D. and Brazier, M. (1998), 'Supply of medicines: paternalism, autonomy and reality', *J Med Ethics*, 24 (2), 93-8.
- Price Commission (1976), *Prices of Private Spectacles and Contact Lenses* ([S.l.]: Price Commission : H.M.S.O.).
- Price Commission (1979), *Dollond and Aitchison Group - prices, charges and margins for optical products* (London: H.M.S.O.).
- Propper, C., Rees, H., and Green, K. (2001), 'The demand for private medical insurance in the UK: a cohort analysis', *Econ J (London)*, 111 (471), 180-200.
- Pulse (2002), 'Key drugs may go over-the-counter', *Pulse*, (11 February), 20.
- Raison, Timothy (1990), *Tories and the welfare state : a history of conservative social policy since the Second World War* (Basingstoke: Macmillan) 218p.
- Rajagopalan, N and Rasheed, A.M.A (1995), 'Incremental models of policy formulation and non-incremental changes: critical review and synthesis', *British Journal of Management*, 6, 289-302.

- Reik, Theodor (1948), *Listening with the third ear; the inner experience of a psychoanalyst* (New York,: Farrar, Straus) xiv, 514 p.
- Rico, A; Costa-Font, J (2005), 'Power rather than Path Dependency? The dynamics of institutional change under health care federalism', *Journal of Health Politics, Policy and Law*, 30 (102).
- Ridley, Nicholas (1988), *The local right : enabling not providing* (London: Centre for Policy Studies).
- Rivett, Geoffrey (1998), *From cradle to grave : fifty years of the NHS* (London: King's Fund) xv, 506 p.
- Rivett, Geoffrey 'NHS Reorganisation 1974', <http://www.nhshistory.net/chapter%203.htm#NHS_reorganisation>, accessed 15 August 2012.
- Robb, Barbara (1967), *Sans everything: a case to answer; presented by Barbara Robb on behalf of Aegis* (London, Nelson).
- Robb, D and Brown, P (1984), 'BUPA 1968-83: A continuing history (Quoted in Foubister et al, 2006:10)', (BUPA).
- Roberts, Nancy C. and King, Paula J. (1991), 'Policy Entrepreneurs: Their Activity Structure and Function in the Policy Process', *Journal of Public Administration Research and Theory: J-PART*, 1 (2), 147-75.
- Robinson, Ray, Patel, Darshan, and Pennycate, Rowena (2004), *The economics of dental care* (London: Office of Health Economics) 72 p.
- Ross, Fiona (2007), 'Questioning path dependence theory: the case of the British NHS', *Policy & Politics*, 35 (4), 591-610.
- Rutter, Paul M. (2012), 'Over-the-counter medicines: their place in self-care', *British Journal of Nursing*, 21 (13), 806-10.
- Sartori, Giovanni (1976), *Parties and party systems : a framework for analysis* (Cambridge Eng.: Cambridge University Press.) 2.
- Schanschieff, S. G. (1986), 'Report of the Committee of Enquiry into Unnecessary Dental Treatment', (London: HMSO).
- Schutze, F (1992), 'Pressure and Guilt: War Experiences of a young German soldier and their biographical implications', *International Sociology*, 7, 187-208, 346-67.
- Thatcher Foundation Archive.
- Seldon, Anthony and Collings, Daniel (2000), *Britain under Thatcher* (Seminar studies in history; New York: Longman) xiv, 142 p.
- Seldon, Arthur (1986), *The riddle of the voucher : an inquiry into the obstacles to introducing choice and competition in State Schools* (London: The Institute of Economic Affairs).
- Smee, Clive (2005), *Speaking truth to power : two decades of analysis in the Department of Health* (Abingdon: Radcliffe) vii, 226 p.
- Smee, Clive (2006), 'Interview: 7 June 2006', (Royal Society of Arts, Manufactures & Commerce (RSA)).
- Smith, Lesley M. (1988), *The making of Britain : echoes of greatness* (Basingstoke: Macmillan Education).
- Social Services Committee (1980), *Twelfth Report, Session 1979-80. The Government's White Papers on Public Expenditure. The Social Services* (HC-702: London : H.M.S.O., 1980-).
- Streeck, Wolfgang and Thelen, Kathleen Ann (2005), *Beyond continuity : institutional change in advanced political economies* (Oxford ; New York: Oxford University Press) xviii, 290 p.
- Summer, Charles E. (1980), *Strategic behaviour in business and government* (Boston: Little Brown & Co).
- Susan, E. Dudley (2011), 'Alfred Kahn: 1917-2010', *Regulation*, 34 (1), 8-12.
- Sutton, Rebecca (1999), *The policy process : an overview* (Overseas Development Institute).

- Taylor-Gooby, Peter (1981), 'The New Right and Social Policy', *Critical Social Policy*, 1 (1), 18-31.
- Taylor, David (1983a), *The consumer movement, health, and the pharmaceutical industry : the sixth in a series of Office of Health Economics monographs dealing with aspects of the prescription medicine market in Britain* (London: The Office).
- Taylor, David (1983b), *The consumer movement, health, and the pharmaceutical industry* (London (12 Whitehall, SW1A 2DY): Office of Health Economics).
- Teeling-Smith, George (1984), 'A New NHS Act for 1996?', (London: Office of Health Economics).
- Teeling Smith, George (Ed) (1985), *Health, education and general practice : Discussion Meeting : Papers*.
- Telegraph (2009), 'Obituary: Sir Alan Walters', *Daily Telegraph*, 5th January.
- Thaler, R (1980), 'Toward a Positive Theory of Consumer Choice', *Journal of Economic Behavior and Organisation*, 1 (1), 39-60.
- Thatcher, Margaret (1993), *The Downing Street years* (London: HarperCollins) 914p.
- Thatcher, Margaret (1995), *The path to power* (London: HarperCollins).
- Thunhurst, Colin (1982), *It makes you sick : the politics of the NHS* (London : Pluto, 1982 (1983 [printing])).
- Times (1984), 'Editorial: Prescribing propaganda', *The Times*, 13 December.
- (2002), 'Affair helped in hindering attempt to privatise NHS', *The Times*, 30 September.
- Timmins, Nicholas (2001), *The five giants : a biography of the welfare state* (Rev. & updated ed edn.; London: HarperCollins) xvi, 708 p., 12 p. of plates.
- Timmins, Nicholas (2008), *Rejuvenate or retire? : views of the NHS at 60* (London: Nuffield Trust) 176 p.
- Timmins, Nicholas (2012) *Never Again: The Story of the Health and Social Care Act 2012* [online text], Kings Fund <http://www.kingsfund.org.uk/publications/never_again.html>
- Titmuss, Richard M. (1950), *Problems of social policy* (History of the Second World War United Kingdom civil series; London: H.M.S.O. : Longmans, Green) xi, 596 p.
- Tomlinson, Bernard (1992), *Report of the inquiry into London's health service, medical education and research ; presented to the Secretaries of State for Health and Education* (London: HMSO) 67 p.
- Townsend, Peter (1962), *The Last Refuge. A survey of residential institutions and homes for the aged in England and Wales. [With plates.]* (London: Routledge & Kegan Paul).
- Tsebelis, George (1990), *Nested games : rational choice in comparative politics* (California series on social choice and political economy; Berkeley: California University Press) xiv, 274 p.
- Tsebelis, George (2002), *Veto players : how political institutions work* (New York Princeton, N.J.: Russell Sage Foundation ; Princeton University Press) xvii, 317 p.
- TSO (1999), *With respect to old age : long term care - rights and responsibilities (Cm 4192-1)* (The Stationery Office).
- (2011), *Fairer care funding : the report of the Commission on Funding of Care and Support. Volume 1* (London: Stationery Office).
- Tuohy, C (1999a), *Accidental logics : the dynamics of change in the health care arena in the United States, Britain, and Canada* (New York: Oxford University Press) xiii, 312.
- Tuohy, C (1999b), 'Dynamics of a changing health sphere: the United States, Britain, and Canada', *Health Affairs*, 18 (3), 114-34.
- Vachers (1993), *BBC-Vachers Biographical Guide* (London: BBC & Vacher's Publications).

- Verschuren, Piet J. M. (2003), 'Case study as a research strategy: some ambiguities and opportunities', *International Journal of Social Research Methodology*, 6 (2), 121.
- Wagner, Gillian (1988), *Residential care. [Vol.1], A positive choice : report of the Independent Review of Residential Care* (London: H.M.S.O.).
- Walt, Gillian (1994), *Health policy : an introduction to process and power* (London ; New Jersey: Zed Books) 226 p.
- Wanless, Derek (2002), *Securing our future health : taking a long-term view : final report* (London: Treasury) 163 p.
- Warden, John (1995), 'Mrs Bottomley and the London lynch mob', *British Medical Journal*, 310 (6985).
- Webster, Charles (1988), *The Health Services since the War* (1).
- Webster, Charles (1996), *The health services since the war the national health service 1958-1979* (Peacetime history; London: H.M.S.O.) xiv, 988 3 maps, ill.
- Webster, Charles (1998), *The National Health Service : a political history* (Oxford: Oxford University Press) 241.
- Welshman, John (2005), 'Ideology, Social Science, and Public Policy: The Debate over Transmitted Deprivation', *Twentieth Century British History*, 16 (3), 306-41.
- Willetts, David (1989), *Reforming the Health Service* (London: Conservative Political Centre).
- Willetts, David (2006), 'Interview: 4th June 2006', (London).
- Williamson, J and Doig, William (1978), 'General Ophthalmic Services - A practical alternative', *British Medical Journal*, 2 (6150).
- Wilsford, D (1994), 'Path dependency, or why history makes it more difficult but not impossible to reform health care systems in a big way', *Journal of Public Policy*, 14(3), 251-63.
- Wistow, G (1988), 'Offloading responsibilities for care (quoted in Mohan 1995:113)', in Maxwell R (ed.), *Reshaping the NHS* (New Brunswick & Oxford: Transaction Book), 153-69.
- Wright (1997a), 'Dentists' Pay and the National Health Service (Primary Care) Bill', in House of Commons Library (ed.), (97/17; London: House of Commons).
- Wright, Katherine (1997b), 'Dentists Pay and the National Health Service (Primary Care) Bill', (London: House of Commons Library).
- Yates, John (1995), *Private eye, heart & hip : surgical consultants, the National Health Service and private medicine* (Edinburgh: Churchill Livingstone).
- Young, Hugo (1990), *One of us : a biography of Margaret Thatcher* (Rev. edn.; London: Pan in association with Macmillan) xv,589p,(24)p of plates.
- Young, Hugo and Trewin, Ion (2009), *The Hugo Young papers : a journalist's notes from the heart of politics* (London: Penguin).

Annexe 1: Chronology of relevant events 1979-97

1979	<p>General Election: Conservative majority 43</p> <p>Conservative Party Health Study Group advocates charges and compulsory health insurance.</p> <p>Prescription charge increased from 20p to 45p (and annually henceforth)</p>
1980	<p>New NHS consultant contract eases restrictions on private practice.</p> <p>Tax concession to employers providing private medical insurance to employees earning less than £8,500pa (effective 1982)</p> <p>DHSS Guidance HC(80)10: Health Services Development. Health Services Act 1980: Private Practice in Health Service Hospitals and Control of Private Hospital Developments</p> <p>Health Service Bill proposes abolition of free sight tests and dental check – withdrawn</p>
1981	<p>DHSS Guidance HC(81)1: Health Services Management: Contractual Arrangements with Independent Hospitals and Nursing Homes</p> <p>“Care in Action” Handbook for new District Health Authority chairmen emphasises mixed market opportunities</p> <p>Department of Health review of international experience with alternative health funding systems</p>
1982	<p>Leak of CPRS report proposing a private insurance system to replace the NHS</p> <p>Mrs Thatcher: <i>“The NHS is safe with us”</i></p> <p>Office of Fair Trading report on opticians</p> <p>NHS industrial dispute</p>
1983	<p>Griffiths Report NHS Management Inquiry</p> <p>Supplementary Benefit Regulations endorse use for private residential care home fees</p> <p>Three popular medicines switched to Pharmacy status</p> <p>Falkands War</p> <p>General Election: Conservative majority 144</p>
1984	<p>Health & Social Security Act ends opticians monopoly on spectacle sales</p> <p>“Limited List” of products excluded from NHS prescription announced</p>
1985	<p>Provision of NHS spectacles ended, except for special groups.</p>

<p>1986</p>	<p>Opticians monopoly on sale of spectacles ended.</p> <p>Voucher scheme for spectacles introduced, for children and low income groups</p> <p>NHS supply of spectacles ended</p>
<p>1987</p>	<p>General Election: Conservative majority 102.</p> <p>“Black Monday” Stock Market Crash (October)</p> <p>Presidents of the medical Royal Colleges issue joint statement on NHS crisis</p> <p>Treasury provides £100m extra to NHS</p>
<p>1988</p>	<p>Prime Minister announces NHS ministerial review.</p> <p>DHSS split: Kenneth Clarke appointed Health Secretary</p> <p>Griffiths Report Community Care: An Agenda for Action</p> <p>Spectacle voucher scheme extended to contact lenses</p> <p>Free sight tests and dental checks ended</p>
<p>1989</p>	<p>“Working for Patients” White Paper proposed NHS internal market, and tax relief on private medical insurance premiums for people aged more than 60 years. (NHS & Community Care Act 1990)</p> <p>Removal of universal free dental examinations and sight tests</p>
<p>1990</p>	<p>John Major becomes Conservative Leader & Prime Minister</p> <p>NHS & Community Care Act</p> <p>Tax Relief on Private Medical Insurance for over-60s announced</p> <p>Revised Dental contract includes partial shift to capitation payments</p>
<p>1991</p>	<p>NHS internal market introduced, including first wave of GP fundholders</p> <p>First medicines “switch” guidelines issued</p>
<p>1992</p>	<p>General Election: Conservative majority 21</p>
<p>1993</p>	<p>Community Care reforms implemented</p>

<p>1994</p>	<p>Guidance on Operation of the Internal Market</p> <p>Tax Relief on Private Medical Insurance for over-60s restricted to basic rate</p> <p>Types of medicines eligible for POM-P switch extended</p>
<p>1995</p>	<p>Use of Private Finance Initiative to build hospitals announced</p>
<p>1996</p>	<p>Community Care (Direct Payments) Act</p> <p>Partnership scheme for long-term care insurance proposed</p> <p>Dental contract shifts focus to children's dentistry</p>
<p>1997</p>	<p>Primary Care Act allows piloting on new primary care services and local contracting for NHS dentistry.</p> <p>General Election: Labour majority 179</p> <p>Tax Relief on Private Medical Insurance abolished</p>

Annexe 2 : Health Ministers & Special Advisers 1979-97

Date	Secretary of State	Minister of State	Parliamentary Under Secretary of State	Special Adviser
May 1979	Patrick Jenkin	Gerard Vaughan Reginald Prentice/Hugh Rossi (Jan 81-)	George Young Lynda Chalker	Professor Roger Dyson (Industrial Rels, 1 day/wk)
Sept 1981	Norman Fowler	Gerald Vaughan/Kenneth Clarke (Mar 82 -) Hugh Rossi	Lynda Chalker/Tony Newton (Mar 82-) Lord Elton/Lord Trefgarne (Apr 82-) Geoffrey Finsberg	Nicholas True

1983 General Election

June 1983	Norman Fowler	Kenneth Clarke/Barney Hayhoe (Sep 85-)/John Major (Sep 86-) Rhodes Boyson/Tony Newton (Sep 85-)	Tony Newton/Ray Whitney (Sep 84-) John Patten/John Major (Sep 85-) Lord Glenarthur/Bns Trumpington (Mar 85-)	Andrew Turner
-----------	---------------	--	--	---------------

1987 General Election

June 1987	John Moore	Nicholas Scott Tony Newton	Lord Skelmersdale Michael Portillo Edwina Currie	Charles Hendry <i>Melinda Libby</i> (May 1988)
-----------	------------	-------------------------------	--	--

Department of Health created following division of DHSS

July 1988	Kenneth Clarke	David Mellor/ <i>Virginia Bottomley</i> (Oct 89)	Edwina Currie/Roger Freeman (Dec 88)/Stephen Dorrell (May 90) Bns Hooper (Jul 89)	Tessa Keswick (1990)
Nov 1990	William Waldegrave	<i>Virginia Bottomley</i>	Stephen Dorrell Bns Hooper	Lucille Campey (1991) Katharine Ramsay p/t (1991) Richard Marsh (1991)

1992 General Election

April 1992	Virginia Bottomley	Brian Mawhinney/Gerald Malone (Jul 94)	Tim Yeo/John Bowis & Tom Sackville (Jul 94) Bns Cumberlege	Richard Marsh (1991) Tony Hockley (1995)
July 1995	Stephen Dorrell	Gerald Malone	Tom Sackville/John Horam (Nov 95) John Bowis/Simon Burns (Jul 96) Bns Cumberlege	Tim Rycroft Tony Hockley

Sources:

Background knowledge, supplemented by

Special Advisers: Hansard, House of Commons, Written Answers 15 November 1991; 27 July 1990 (Col 424); 1 December 1994 (Col 832); 17 May 1995 (Col 243); 20 March 1995 (Col 723).

Additional information from Richard Marsh. & Charles Hendry MP

Annexe 3 : Treasury Ministers and Special Advisers 1979-97

Date	Chancellor	Chief Secretary	Special Adviser
May 1979	Geoffrey Howe	John Biffen/Leon Brittan (Jan 81)	Adam Ridley George Cardona

1983 General Election

June 1983	Nigel Lawson	Peter Rees/John MacGregor (Sept 85)/John Major	Alastair Ross-Goobey (Apr 86) Andrew Tyrie Peter Cropper
-----------	--------------	--	--

1987 General Election

June 1987	Nigel Lawson	John Major/Norman Lamont (Jul 89)	Alastair Ross-Goobey Andrew Tyrie Peter Cropper Warwick Lightfoot(Sep 89)
Oct 1989	John Major	Norman Lamont	Alastair Ross-Goobey Warwick Lightfoot Judith Chaplin
Nov 1990	Norman Lamont	David Mellor	Alastair Ross-Goobey Warwick Lightfoot

1992 General Election

April 1992	Norman Lamont	Michael Portillo	Bill Robinson P.W. Robinson David Cameron (May 92) R.Darwell (Feb 93) Alison Broom David Hart
May 1993	Kenneth Clarke	Michael Portillo/Jonathan Aitken (Jul 94)/William Waldegrave (Jul 95)	Tessa Keswick David Ruffley David Rutley Edward Troup

Sources:

Background knowledge supplemented by: Hansard, House of Commons, Written Answers, 15 November 1991; 1 December 1994, (Col 803). Additional information provided by Richard Marsh, Christopher Mockler

Annexe 4 - 1980 Memo to Prime Minister on Charges

21000 400 202 110 Econ P21

PRIME MINISTER

Prescription Charges

The proposed saving of £120 million in 1981/82 from raising prescription charges is made up as follows:

	£m	
Increasing the charge to £1 in December 1980	29	75
Introducing a 50p charge for the following who are currently exempt:		
(a) children under 16 (except for those on supplementary benefit and FIS)	21	
(b) women over 60 and men over 65 (except for those on supplementary benefit)	39	
(c) certain groups who are currently exempt for specified medical conditions	2½	18.75%
(d) expectant and nursing mothers	2½	
(e) hospital outpatients	4	25
Dental charges - removing existing exemption for young people who have left school	9	24
Optical charges - £2 for a sight test (except for people on supplementary benefit and FIS who will continue to be exempt)	11	53

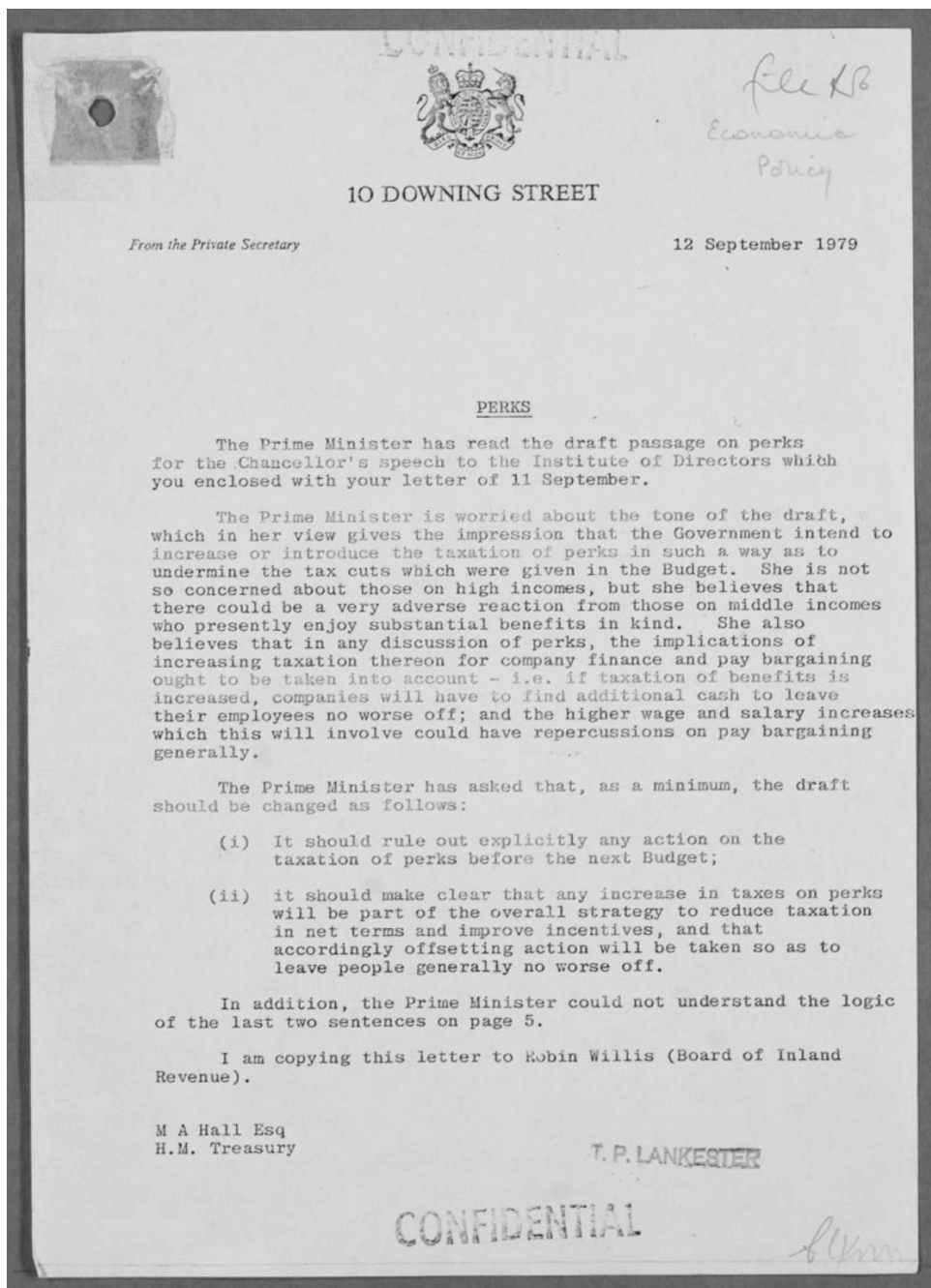
Thus, if we were to take out all the changes in exemptions, we would lose about £90 million out of the £120 million. Politically, I would have thought that the last three of the changes given above would be the easiest to defend. If we included these in the package but not the other four, the total saving would come to about £53 million.

DES. 81-82 5-10 FL. 167

31 January 1980

We have ~~got~~ to get
economics

Annexe 5 - PM 1979 note to Treasury on "perks"



Source: Thatcher Foundation Archive

Annexe 6 – Edwina Currie diary August- November 1987

These extracts include previously unpublished material¹⁴⁹

John Moore and the National Health Service.

See also; (Currie 2002).

31 August 1987

What do we think of them all? Moore is Kennedy. Clean looking and (apparently) clean living; clever, pretty, ambitious wife. He is keen to have team work, which suits me – Fowler sucked people dry + then discarded them (Wardle, Heyhoe, Whitney, Newton and others) but JM asked for opinions on Social Fund from all Ministers and got them. But his political judgement is hasty – he tried to ditch Social Fund after all those hours we put in (200+) on Bill, and all the commitments given by Willie Whitelaw et al. He wrote letter to John Major (who put Bill through) saying SF was politically indefensible!! Then he found himself opposed in Cabinet by Major, Fowler (ditto) and Whitelaw amongst others. If he had thought twice he would not have tried it on, but he's angry at NF for leaving so many blank cheques (promises to Treasury about savings, which are (a) vague and (b) difficult, especially with AIDS problems) and he wants to show he's smarter. I'm not sure he is. Portillo, who has worked with him before, says he's 'sold as seen' – there is no secret man. In that case, Moore is also intolerant and somewhat arrogant, despite the carefully offered charm; but he's also insecure, and surrounds himself with evidence of his already achieved high office, eg the toys we are presented with on official occasions – his office is full of them (mine are languishing in a box in the kitchen!).

9 September 1987

Found myself wondering about Tony Newton – most of the stuff in boxes has been through his hands + he seems to find it increasingly difficult to take a decision. He will have completed 7 years in DHSS by the next reshuffle: maybe all I have to do is sit tight¹⁵⁰. But we need his brains. So far I doubt if John Moore has the same quantity. Last week he made a speech on privatisation in the USA which caused a stir here, leading articles etc, partly because he claimed to be sole begetter of this jewel in Margaret's crown ("I" everywhere, not "we") and partly because it's seen as bid for the leadership when there's a vacancy. But: he's got probably 4 yrs at DHSS and he's not going to be able to privatise it. A real thinker would be looking ahead, not claiming the past. Ken Baker is brainier I think and has greater vision and so far still has my preference.

27th September 1987

¹⁴⁹ Member of Parliament, Derbyshire South 1983-97. Parliamentary Under Secretary of State for Health 1987-88. Councillor, Birmingham City Council 1975-86

¹⁵⁰ Until promotion

Someone with his eye firmly on the leadership is J Moore who made a strong speech on social security and getting away from the welfare state this week – it did cause a stir! It isn't original and he will find it difficult. There's a naivety about him, and an arrogant intolerance, that comes from a man of not excessive ability in a hurry. One adjective I should not use to describe him is "wily," but Baker is, + so is John Major. Hurd wants it too but he's so boring.

Moore will come up against what Boyson called the "dog and bone" syndrome – you can't take a bone from a dog that's already eating. There are only 3 groups/benefits Moore can tackle: pensioners (but they paid, and there are 10 million of them), child benefit (but the Tory ladies like it – I don't, but they are powerful) and the disabled (he hasn't met them yet. Just watch!!).

Let it be recorded that the origin of his thinking is Charles Murray's "Losing Ground," (Murray 1984) but it was sent to him after the election by Keith Joseph. If Moore were the brains he thinks he is he'd have read it before – it was published in '84 in the USA. The same goes for me too, of course! It is fascinating, and devastatingly accurate in its view of why more welfare makes things worse, particularly in its destruction of the status rewards of being respectable, law-abiding etc. Chilling reading. Where it's hopeless is what to do about it!! Just abolishing the system won't work - and in a democracy it requires a vote or two in a free Parliament to do it. Well, we shall see."

5th October 1987

Quite a week! "Thinking Day" (actually 2pm Thurs – 2pm Fri) at Chevening was quite something. Firstly it's an extraordinary place: looks imposing from the outside but is stunning inside, beautifully kept, original furniture etc – just as old country houses used to be, I imagine, in the days of plenty of servants. And there were servants too – in striped pants and arrogantly obsequious, talking as if they were Sir Geoffrey's¹⁵¹ personal staff + as if he was paying for the place! I don't really like being served all the time – I find formality oppressive, especially when they insist on putting the cheese plate in front of me when I don't want it. The rooms, ceilings etc are fabulous. We did most of our work in the 'Tapestry Room' ablaze with 18thc tapestries barely faded, with peacocks and lions leaping out at us. Out of a window, beyond the lake, was a hayfield, lazily dusty on a sunny afternoon, with a combine harvester making golden cylinders as the shadows lengthened. Best of all: the library with an unbelievable, priceless collection – texts of Aristotle from the 16thc, Thomas More's Utopia, first editions of Isaac Newton and Adam Smith (signed!), original prints of Warren Hastings' and Queen Charlotte's trials etc. That was worth the visit alone. John Moore has been there several times as the Treasury team go in January for the first budget discussions. He wants to go again next year and we concur!

The team was: 6 Ministers, JM's Private Sec Geoffrey Podger (who listened – no notes), Andrew Turner and Paul Godfrey from CCO. We talked first about social security, about "doing a Murray" on the benefits system. There are 4 possibilities: enforce regs (eg insisting an availability to work), changing them to make them

¹⁵¹ Sir Geoffrey Howe MP

tighter (eg no dole for under 21s if training available), cutting value of benefits or cutting out a benefit. We fudged the latter two. It appears that Norman Fowler promised in a previous PES round that Child Benefit will be frozen anyway from next year – Moore v angry at the pre-emption of his decision-making power – but manifesto promised it would stay more or less as present. We decided that looking after elderly pensioners better was, however, a “non-Murray” event, i.e. there was no disincentive effect to giving more money to those who can’t get SERPS (roughly over-75s). We talked about equality of age of retirement and decided on 65 for both¹⁵² (more money to Treasury of course. And unemployment is less of a problem, while unfavourable changes in the ratio of earners to elderly dependents is more esp. as we head towards 2000 AD). Broadly speaking I think the social security proposals are good + will be welcome in the country. I’m more concerned about health: we thought the ideas were John’s own but it’s clear from today’s Independent that they come from Margaret and they don’t really answer the problem, which is, how to match increased demand for health? She/he wants to ‘meld’ the state and the private sector by getting the NHS to behave more like a private operator (or rather a collection of geographically sparkling operators). If one has spare capacity, the DHA can “sell” it to others or to the private sector. They’re thinking of Bart’s which is planning to lease a whole wing to the private sector. (She also wants medical audit as to why waiting lists and cost per operation are higher in some patches than others, but that didn’t come up at Chevening). The problems are, that the private sector won’t like it – they’d like NHS pay beds abolished not increased; the staff won’t like it, they are already resentful of doctors making money out of sickness etc; it will take a lot of management time and effort, with the main result of increasing output without increasing input which is already a problem (since it pushes up costs sharply). The only reason any NHS facility has spare capacity is because they haven’t the conventional finance to run it (“the cuts”) and there isn’t a DHA in the country with spare cash. Most of all it’s a solution which doesn’t address itself to the main problem namely how to dig out a steady and substantial increase in resources to keep up with the growth in demand! We’ve seen 5-7% jumps in numbers of patients treated in many HAs in the last 12 months. If this keeps up, the total spend on health will have to rise from its current £21bn (+£¾bn private) to (say) a total of £30bn by the next election. And just swapping resources around through some limited, primitive and (probably) arbitrary pricing system won’t generate an extra £8bn. In any case there is an assumption that the present allocation is necessarily inefficient and I don’t agree; whereas any internal market will respond to the energy and initiative of the big London teaching hospitals and will drain money down from the midlands and the north. That will suit Bart’s and Guy’s down to the ground of course but it negates RAWP and is quite simply not what we’ve been trying to do. (It is not inefficient to allocate money instead to Sheffield and Newcastle, in my view).

My feeling is that we can fund limited growth in NHS – say up to £27-28bn – and expect the rest from private sector (say, → £2½bn). Now that implies v rapid growth of private, but I don’t see why not – the essential prerequisite, a large number of fairly well off people, is being met. We agreed to seek tax relief on BUPA subscriptions for the over 75s as they do have to pay extra – doubt if the

¹⁵² Announced in the 1991 Budget

Chancellor will agree, but worth trying¹⁵³. And to explore a voucher system (as with specs) for hearing aids, wheelchairs¹⁵⁴, and possibly selected ops like hip replacements. I pointed out the problem Keith Joseph had with universal vouchers for education – the admin complexity – but you could do it for certain types of shortage, priority surgery easily enough. There are precedents in housing eg sheltered housing owned by council. Any further changes require modification of 1977 NHS Act which forbids charging – will be looked at, but it could paradoxically cost us a fortune as the DHAs will start charging their MH and Mill patients for staying in hostels + the income will come from DHSS! So the Treasury may have a view.

8 November 1987

Only seen John Moore briefly this week: no meeting on Monday as he was preparing for the 2nd Reading of the Social Security Bill that day, and no meeting Wednesday – no reason given. But as I see his comments on policy papers he goes down in my estimation – I don't think he understands the NHS, its scale, its problems. He failed to get enough capital for the breast cancer programme and has been sending out petulant memos saying that with a £1billion capital programme it should be easy for the RHAs to find the money needed. But all that £1billion is committed and something would have to be cancelled (it's over-committed and they are already postponing projects eg in Burton on Trent). But it's more the principle – we should have learned something from the cervical cancer shambles when health authorities were told what to do but given no money. Well, I learned, and the officials learned, and Sir Roy Griffiths (who is sending round cross memos about it) learned, but JM has nothing to learn, he knows it all. It's the same with hospitals charging for paybeds. The PAC criticised us last year for undercharging, which our friends in AMI don't like either, - they accuse us of undercutting them and after 10 years in the UK they are only just starting to make a profit. Now JM wants the NHS actively to compete with the private sector (why? seems illogical to me) and is quite keen on loss leaders. Tony and I have both pointed out that will bring criticism from enemies and friends, but in another petulant little note he says it's the scheme he wants. So much for working as a team. Perhaps like many people from a very difficult background he is so insecure that praise and glory are all he wants to hear. B¹⁵⁵ is very critical of him too and gave me to understand JM could have had more money in the recent PES round if he'd boxed cleverer. In the end we got £700 million extra which will only be enough if the pay rounds in the spring are very mean; otherwise, if they are around 8% for nurses, which seems likely, we are £150m adrift. That works out at nearly £1million per DHA, and that is nasty. There's a big contingency reserve so maybe we will be rescued but the figures already have a secret pay assumption built in. I think it will be tight till the run-up to the next election, and I was suggesting to Tony that, if we must introduce Project 2000 (which will take nurses off the wards and make them students, and

¹⁵³ Introduced in 1990

¹⁵⁴ Partly introduced in the Community Care (Direct Payments) Act 1996

¹⁵⁵ John Major, Chief Secretary to the Treasury

which will cost a packet) we should introduce the legislation soon, with implementation after the next election!

29 November 1987

For the govt on the NHS it has been a ghastly week. The DHAs have done their sums, the RHA chairmen met us in Cambridge the previous Wednesday and we outlined PES to them and everyone is feeling very pessimistic. We've been given £700 millions next year, which is 1.7% in real terms and it's nowhere enough. We now spend 5.2% of GDP (net) on the NHS, 5.9% if private care is counted, and that's one of the lowest % in the developed world. When I was preparing a speech 10 days ago for the Healthcare Financial Management Association (erstwhile Treasurers) I naturally assumed the % was rising; to my amazement no, it's due to go down to 5.1% by 1990. So I thought, sod it, I bet Moore intended that, and everyone should know: so I said it, and it was picked up by Nick Timmins, the bright lad who writes for the Independent, and now they do. On Thursday during the debate I was checking with officials in the box (the Press office had backed off and said the remarks were "unscripted" which is crap. I wish they would stop apologising for me). I asked them, wouldn't it be possible to negotiate PES the other way round? Instead of starting with this year's budget and then hassling over additions, why not start with the figure we thought we should be aiming at, eg 5.5% of GDP, and make comparisons with other countries? Yes, they said, we did suggest that to S/S but... How very interesting. We are very stuck with the NHS. We want to boast about how better we fund it than everyone else; yet S/S wants to be macho by not pleading for more money. At the same time demand for health care has had a hefty hike recently, as transplantation is so successful, as new anaesthesia makes surgery safe even for the frail and as we head for 4½ million people over 75. I know (and said it in debate) that there's no cash figure which is 'enough' but I suspect there are some years eg 1985-87 when it is closer to 'enough' and others like now when the gap is widening. The crux of the row this week was over a hole in the heart baby in Birmingham who had his op cancelled 5 times, because of lack of nurses to operate the ITU. Fortunately some came back off sick leave and he was done on Wednesday, but it's an old story at Birmingham, and Leeds and many other places – they don't train enough specialised nurses, then they don't manage them properly, so they get tired and disillusioned and clear off. They had the same problem at Birmingham 10 years ago of children being refused admission: then the ITU was full of kids with whooping cough, dying. In 10 years' time it could be AIDS or God know what: but it will be something. I suggested to Tony that we should have a central fund to help with the training of specialist nurses, as it is beyond DHAs' means (they not only have to pay training costs, but costs of cover too) and the RHAs have been very dozy about it. If we give a 50% training grant, and expect the RHAs to give the other 50% we may get somewhere. And we have to pay them better but there are discussions under way about that. And the PM suggested on Monday that we should move to a 2 or 3 year agreement for staff which would be wonderful – get them out of our hair for a while – but it would have to be generous to be acceptable. We shall see.

And so to the PM of whom I've seen a lot this week. Lunch at No 10 Monday (23 Nov 87): 5 Cabinet Ministers (Whitelaw, Young, Wakeham, PM and Waddington,

with Peter Brooke) and 1 M/S (Ian Stewart, Defence who hardly got a word in) and 4 PUSs (Richard Needham, N. Ireland, Colin Moynihan, Sport, John Lee, Employment – also fairly silent) and me. Archie Hamilton her PPS was at the far end of the table. Mostly she went on about the NHS and how we are going to have to reform it quicker than expected, in the Parliament. She did not specify what she had in mind but she's wide open to the ideas of people like John Peet, John Redmond, David Willetts, all young, fit, wealthy and ignorant, and where they're not wealthy yet, at least trying to forget their poor past. Some of the ideas are inconsistent, eg, why not pay hospitals per operations and then they'll have to be efficient? (this is like the Diagnostic system in the USA which has resulted in the wholesale sacking of nurses). But Prime Minister, I ventured, we do that with dentists now; it does not guarantee efficiency, it discourages prevention and it conflicts with the cash limit controls. I think she's after a 'money follows the patient' idea; certainly you could use a voucher system for a few limited things, but God help the bureaucracy if we did it on a grand scale. Anyway it doesn't by itself create more resources and if we're not careful it just means a drain of NHS money into the private sector where they offer us loss leaders. She also told me gaily that you can't prevent a heart attack to which I said, "Well, they did in the USA, and strokes," so she changed the subject. Maybe she realised she was talking nonsense. She also said rather gaily at lunch that all the world leaders have low blood pressure, she herself has low BP. I said those with high BP keeled over years ago. Can you imagine her discussing BP with Reagan or Gorbachev? The mind boggles. As it happens she felt faint herself the following eve at Buckingham Palace and had to go home early; why do people like her and Moore think they are such supermen!

Meanwhile there are genuine souls like Tony Newton, slaving away, teeth gritted, on proposals to charge everyone through the nose for their teeth and defending the govt's handling of the NHS against the screaming mob which is the modern House of Commons (doesn't bother me, I just shout back).