The Miner's Canary, let it fly

Inaugural Professorial Lecture

given by

Tony Beddow

Visiting Professor, Welsh Institute for Health and Social Care

Introduction

That in my seventh decade I should be inaugurating anything but an argument in a room shows that this University has a sense of humour and courage. Yet argument would be a fitting outcome from tonight as I profess three things.

First, the fundaments of the NHS owe much to Welsh history and a relationship with England that caused Wales to shape this social innovation. Maybe the English were too subservient, the Scots too distantly independent, and the Irish busy breaking free of the Union, to create our NHS.

Second, the characteristics of the NHS were not carelessly endowed. National in coverage, centrally planned, funded by taxation, and intended to blend preventive, diagnostic, treatment and aftercare services into one logical system, although presently unfashionable, their relevance will increase not diminish.

Third, far from eschewing the analysis and values that shaped the NHS, we must state more loudly what past generations so painfully learned. As England moves away from the NHS we know, the inspiration that is the NHS needs travel abroad.

My lecture has four parts. Part one explores the contribution of two politicians forever associated with Wales, David Lloyd George and Aneurin Bevan, their backgrounds, and their views of the fundamentals of a health care system. The recent history of Wales which shaped the birth of the NHS, and the nature of the Welsh middle class holding the key to the type of public service it is possible for Government to create are touched upon. Without middle class support for publicly provided schools, hospitals, and other services, public provision becomes a safety net for the poor. The Welsh middle class was distinctive.

Part two draws upon lessons from the sophisticated world of finance from which it is clear that if Adam Smith's "invisible hand" ever was skilled at distributing resources, that hand is increasingly grasped by mighty international companies. Were the NHS to be privatised, such a grasp would tighten around regulators of health care as it did around regulators of finance.

Part three explores the nature of health care systems, challenging the nostrums that markets, competition and consumers are all and that the social solidarity of the NHS is passé.

When Lloyd George and Bevan learned their political craft, Wales mined coal and miners took a canary in a cage as an early warning system. Part four concludes my lecture by imploring the

miner's canary to sing its song for those just a bridge toll away, and others who have yet to learn, or wish to ignore, why the NHS is among the most successful health care systems in the world.

Part One: The NHS and Wales

History of the Wales

Wales' history offers clues as to why the architects of the NHS found political inspiration here. Wales of 1750 had about half a million people with Denbigh, Flint, Monmouth and Glamorgan growing as birth rates rose and migrants came to the new industrial communities. Such change pressurised the propertied classes and property was concentrated in fewer hands. In many country families established dynasties disappeared and estates transferred to absentee English landowners. Although agriculture declined, land ownership still conferred status and power. Owner-occupied land in Wales was rare; instead tenant farmers provided income for Anglican gentry and although absentee landlords were largely despised, class distinctions between tenant farmers, labourers, and servants, were not pronounced.

In early 19th century Wales 80% of its population was in rural Wales; by 1911 only 20% was. In the Boroughs class conflict arose from economic downturns and disease. Ordinary ratepayers came into politics through machinery created to operate the 1848 Public Health Act and the 1834 Poor Law Amendment Act, and through chapels, Unions and Friendly Societies. Real or personal property was a qualification for election to a Board of Health until 1882 so it was inevitable that the middle class would play a crucial part in the public health movement. But that limited franchise also meant that Boards of Health were often reluctant to spend money. Another fifty years would pass before a wider franchise and an organised labour movement could influence public policy.

Ill health was largely an urban issue with preventive health matters the preserve of local authorities. Cholera visited Cardiff, Newport and Merthyr in 1849 and some historians claim that the counter measures it inspired did more for working class health than did political revolution.

By 1876, 50% of adult males were in friendly societies and Wales was predominantly non conformist; the established church remained in rural settings rather than spreading to the fast-growing towns. Non conformism created a socio-political consensus, partly because the laity and the non- conformist ministry shared the same lifestyles, but also because chapel offered basic education to, and a focal point for, the community.

Enlightened employers sponsored education and health services, for example the schools at the Esgair Hir Mines, North Cardiganshire and Neath Abbey Ironworks (which also provided medical cover from deductions from wages). Merthyr ironmaster William Crawshaw led the petition for parliamentary reform in response to the Corn Laws and in 1831 he led protesters against the MP for Brecon, Colonel Wood. Aberdare and Merthyr miners, shopkeepers and professional people came together in "political –union" clubs as the movement for political reform and working class interest in parliamentary affairs both grew.

After the Merthyr and Rebecca riots (1831-1843) and the 1839 Chartist attack on Newport – largely supported by the middle classes - Parliament studied the state of Welsh education. The 1847 "Blue Books" painted a picture of the Welsh as ill educated, poor, dirty, unchaste and

potentially rebellious. This provoked uproar, united non conformist opinion, and further alienated Wales from Anglicanism. A cultural and political shift to non-conformism occurred. Attention to knowledge, progress, and self improvement replaced poetry and legends. Non conformist journalists, preachers and politicians were the new heroes.

D. Gareth Evans[1] concludes that non conformity, and industrialisation based on steel and coal forged the new politics. Middle class radicals with working class interests turned Welshmen from Methodism to Marx. Kenneth O. Morgan[2] cites Henry Richard addressing the then political elite through the newly enfranchised voters of Merthyr, imploring them to elect him to challenge English speaking landed gentry in the name of non conformism. “This country is ours, not yours and therefore we claim to have our principles and sentiments and feelings represented in the House of Commons”. Richard’s election saw Wales attain recognition in the governance of Great Britain which Lloyd George exploited.

Lloyd George and Bevan

I turn now to key players in the formation of the NHS, Lloyd George and Nye Bevan. Lloyd George brought in the 1909 budget and the 1911 National Insurance Act providing for the first time and through deliberate central government action, primary medical care for working people and their wives. Bevan’s National Health Service Act provided hospital care and paved the way for a health care system to be built. Although supported by Asquith and Attlee, their contribution to the NHS is theirs alone. Wondrous powers were attributed to them; Lloyd George the “Welsh Wizard”, Bevan “the magician”.

Both are regarded as great Welsh politicians, although Lloyd George was Manchester born. Both were acknowledged public and Commons orators. Lloyd George addressed 3,000 people in Birmingham Town Hall in June 1911 to explain his Insurance Bill; 70,000 applied for tickets.

Both from strong non-conformist backgrounds, neither felt inferior alongside their “betters”. School boy Lloyd George led a school revolt against saying the Anglican catechism. Bevan was Lodge Chairmen by 19 and a local councillor at 25. Both were advocates - Lloyd George a solicitor, Bevan a full time Trade Union officer. Both were “self taught”, Lloyd George drew upon his father’s library whilst Bevan developed and used the library services of his Union and local Council.

Both used life experience to shape the state’s response to problems. Lloyd George noted the Baptist Chapel’s use of collection money to support its sick fund while Bevan knew the Tredegar Medical Aid Society where miners paid 3d in the pound to access free medical care from society-employed doctors.

Their judgement came from their “Welshness”. For Lloyd George it was the established church and English landowning classes close to it that drove him to support an independent Wales and to despise the landed classes that contributed little, especially when an unelected Lords (“500 people chosen by accident from the ranks of the unemployed”) rejected his 1909 budget. For Bevan, Marxism, the power of landowners and capital, and the working of the international

[1] Evans, D. G. *A History of Wales 1815-1906,* University of Wales Press, 1989
[2] Morgan, K.O. *Wales in British Politics 1868-1922*, Cardiff, University of Wales Press , 1991

capitalist system which dictated how wealth was shared among the main classes, determined him to gain and use political power for his class.

Both saw how spending on weapons denied spending on public services. Lloyd George resisted a clamour for dreadnoughts as German naval power grew; Bevan opposed the re-armament that threatened his NHS and ran counter to his analysis of international affairs. Both rejected the notion of voluntary insurance. Lloyd George, having studied Bismarck's system, determined upon compulsory insurance for his scheme. Bevan – fearful of high and cyclical unemployment in Wales - chose to fund the NHS from general taxation.

Both were outsiders - irritants to their parties- yet Campbell[3] asserts that Bevan was never a happy rebel. Both used politics and state power to deliver for the disadvantaged. Lloyd George was determined that the Lords would not frustrate the Commons and his spending plans; Bevan determined that the BMA, the Tories and the press would not derail the will of the Commons and his1948 Act. Both used charm, intelligence, and political bravery to counter opponents. Complaints often are heard that the NHS should be free of politics; yet without politics and politicians it would not have been created.

There were differences. Before the Great War Lloyd George introduced compulsory health insurance for the less well off against their will. After the Second World War Bevan made real the wish of a generation that knew why war had been waged, and what peace should deliver. Lloyd George travelled lightly in terms of political philosophy and was considered to be ambitious whereas Bevan by his own writings and speeches, and confirmed by Foot[4], was a political thinker framing his approach to politics from a Marxist analysis.

On Lloyd George's death, Bevan reflected on his (and Churchill's) years without office thus. "It must cause some of us to feel extremely humble because there were two of the most eminent and brilliant parliamentarians of this era denied employment by the State… even the most superabundant qualities are irrelevant if not associated with great mass (Party) machines". Bevan stayed in the Labour Party against the odds. Lloyd George was never a "party man".

David Lloyd George

Born in Manchester in1863, by 1890 he was M.P. for Caernarvon Boroughs. He came to politics with social unrest in the air, The condition of the poor was being documented; for example the state of recruits for the Boer War lead to improvements in standards of nutrition for school children.

Emrys Price[5] believed that Lloyd George's social reforms were driven by Welsh values and his non-conformist background. He read constitutional history, Dickens, and Les Miserables and his experience of the Anglican Church and the landowners supporting it created a sense of injustice that fired his politics. Price concludes that Lloyd George, sensing the coming of the Labour Party, aimed to change Liberal sentiment to identify it with the poor.

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[3] Campbell J. *Nye Bevan: A Biography*, Richard Cohen Books, London 1997
[4] Foot M. *Aneurin Bevan* Indigo, 1997
[5] Price E. *David Lloyd George*, University of Wales Press: Cardiff, 2006

A.G. Gardiner[6] observed "Lloyd George will succeed in proportion to his fidelity to the inspiration not of Westminster with its intrigues, but of Wales with its simple faith". He was the great improviser of politics who once told Gardiner "England is based on commerce….no party can live by an appeal to labour alone: it must carry the commercial class as well as labour with it".

Always an outsider in relation to the ruling Liberal elite[7] as emphasised by the title of Hattersley's biography, by the end of his premiership Lloyd George was effectively outside the party. He championed Home Rule for Wales when this was unpopular and was not afraid to use the Welsh Liberals as a semi-independent party to establish his radical reputation. Having left office, his 1929 manifesto *"We Can Conquer Unemployment"* proposed publicly funded work programmes. He recognised the economic "multiplier effect" seven years before Keynes published his *General Theory of Employment, Interest and Money.*

His early legal career saw him styled "the people's attorney", blending law and politics. He campaigned against the tithe and for the disestablishment of the church, achieving fame by winning a case against Llanfrothen Church whose rector had refused a nonconformist burial in the churchyard. His 1892 election manifesto proposed an old age pension funded by land taxes. He opposed the 1902 Tory Education Bill which subsidised Church Schools and supported the Workmen's Compensation Act, the Factories and Workshop Act, the Coal Mines Regulation Act and the Trades Disputes Act which negated the Taff Vale judgement.

John Grigg[8] claims "During the Edwardian period the ordinary people of Britain found in a member of the professional classes (Lloyd George) their most eloquent and effective champion". In 1906 Lloyd George said "There is plenty of wealth in this country to provide for us all and to spare. What is wanted is fairer distribution". His later budget was not only a budget to fund the war on Germany, but was also to wage war on poverty by taxing land, industrialists and the middle class. For the first time, a British Government used taxation to serve a social purpose, and was opposed by the Lords for its cheek.

His attitude to the provision of old age pensions, for which Trade Unions had been agitating, was revealing. His scheme was non contributory. His experience was that it was difficult to persuade poor working people to insure against an eventuality that, for many, was remote and hypothetical. He visited Germany in 1908 to study its system of social insurance in preparation for his landmark 1909 "people's budget" that made demands on the rich to aid the poor. Lloyd George (with echoes of Marx) saw it as a war budget, one that waged war on poverty through recognising and countering the cyclical nature of unemployment. As Klein[9] noted the Bismarckian model emphasised individual rights, Lloyd George went for collectivist values.

The political significance of his approach was grasped by Austen Chamberlain and Lord Roseberry, the latter noting it was less a budget and more a revolution. Lloyd George's Limehouse Declaration so alarmed the King that Asquith asked him to tone down the rhetoric to

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[6] Gardiner, A. *Prophets, Priests, and Kings,* J.M. Dent and Sons Ltd, 1914
[7] Hattersey R. *The Great Outsider, David Lloyd George,* Little Brown, 2010
[8] Grigg J. *Lloyd George*: *The People's Champion 1902-1911*, Penguin Books 2002
[9] Klein R. *Politics of the NHS*, Longman 1985

“keep the middle class on board”. Lloyd George’s target however was not the middle class but the landed aristocracy that rejected his budget to prevent it funding social reform.

The 1911 National Insurance Bill compensated for income lost through invalidity, rather than curing sickness. It contended with the remnants of the Poor law (which the poor despised) and the self-help Friendly Societies then serving the aristocrats of Labour whose clubs employed and controlled the doctors who treated their members. Industrial Insurance Societies such as Prudential, and Pearl who provided health cover also had to be faced. Their agents were mainly radical Liberals whose direct contact with clients gave them political influence. Only 37% of the sums paid by policy holders were paid out in benefits; 22% went to pay agents whose influence was such that by the second 1911 election 490 MPs were pledged to oppose any state insurance that took business from them. Political lobbying by commercial health care interests is not a new phenomenon.

For 4d per week from men (3d for women), plus 3d from the employer and 2d from Government, all over 16 years of age and earning less than £160 a year, and all manual labourers, were provided with sick pay of 10 shillings per week for 26 weeks after the ninth day of illness. The right to be treated by a G.P., medicines, access to TB sanatoria, and maternity benefits were included. The scheme was to be administered by local insurance committees having some democratic basis, although industrial societies became eligible insurers without this requirement placed upon them.

Working people had difficulties maintaining cover though friendly societies. They often worked when they were too ill, and were often late seeking medical help. Grigg quoted Lloyd George on tuberculosis: “I really think it is about time that the nation as a whole, that the state, should take the matter in hand, because the state has suffered. It lays bare a good many of these social evils and forces the state to pay attention to them”. Working families were too proud to turn to the Poor Law, “yet while even a brewer’s horse was rested when ill, and machines were serviced and repaired, workers did not appear in ledgers as assets”.

In December 1911 his Bill received Royal Assent following which the Poor Law declined, hospital out patient visits reduced, hospital admissions increased and the Medical Research Council came into being. For their trouble, the Liberals suffered afterwards in by elections because of voters’ unhappiness with the National Insurance Act, the beneficiaries of which did not yet have the vote.

Aneurin Bevan

I now turn to our second Welshman, Aneurin Bevan. Brivati introducing Foot’s biography asks if any other Minister made the same impact upon the political landscape as did Bevan with the NHS, whereas Marquand[10] described Bevan as the greatest tribune of the people of his generation, but a statesman manqué.

Bevan had two core beliefs. First, central planning was a better and more equitable system than the market to deliver social goods; the state was best placed to invest the surplus created by a modern economy. So if a Labour Government could marry central planning to personal liberty, then a society different from those of both the Soviet Union and the United States could be

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[10] Marquand D. *Britain since 1918, The Strange Career of British Democracy*, Phoenix, 2009

created. Second, he eschewed industrial politics as taught by Marx, preferring instead to gain and use parliamentary power to deliver a better social order.

The socialist NHS he bequeathed has become the most stubbornly resilient legacy of the Attlee government. Marquand says “The NHS was the most impressive and enduring of the Attlee Government’s domestic legacies. For the vast majority of British citizens, health care was no longer a commodity to be purchased in the market place, but part of the public domain where market power was subordinate to citizenship rights”.

Born in Tredegar 34 years after Lloyd George of a Baptist father and Methodist mother, Bevan absorbed the self reliance and pride of the non - conformist tradition. At 14, like his father he became a miner. Not fond of school he nevertheless loved books. Noah Ablett’s work, and his experience of the mines, led him to abhor private ownership. He realised that politics was about getting power and was elected MP for Ebbw Vale in 1929, the first general election under universal suffrage when, Foot contends, the era of parliamentary democracy began. Bevan observed that the Churchill’s had been in Parliament for centuries; now the Bevan’s had arrived. Bevan did not “do” deference.

Unlike the Independent Labour Party (ILP) and Lloyd George, Labour had not then adopted Keynesian economics – preferring the Treasury orthodoxy of balanced budgets, following the gold standard, and free trade. Bevan supported ILP’s adoption of a different economic approach to counter mass unemployment. It was the first time, but not the last, that Bevan would be a thorn in the side of his party, urging early support for Spanish Republicans, seeking unsuccessfully to unite the left under the socialist league, and attacking the Labour Chief Whip for inaction when in 1938 Italy attacked British merchant ships.

Bevan (with Cripps) was expelled for opposing the Party on appeasement and Spain, criticising the Party machine for “running an intellectual concentration camp” but, supported by the South Wales Miners Federation, he was re-admitted to the Party in December 1939. Frequent attacks on Government policy and its Labour Ministers led to new calls for his removal but a devastating parliamentary attack on Churchill’s inadequacies as war leader in July 1942 (“the P.M. wins debate after debate and loses battle after battle”) made him the undisputed leader of the Labour left.

He recognised that the war would open previously sealed minds, recruiting thousands into politics who would otherwise stay above the fray. Labour should concern itself with such “eager virgin minds” and emerge with the leadership of the nation after the war. Then, Foot commented, “England caught a glimpse of what a co-operative commonwealth might be”.

Marquand concludes that Attlee’s Government failed to achieve a planned economy, partly because “the high command did not know what it wanted”. Yet Bevan knew exactly what he wanted for the NHS. Marquand felt that “The NHS was a monument to Beveridge’s evolutionary whiggism, but it was also the child of a marriage between democratic collectivist statecraft and professional expertise. Not only did the state suppress the unfairness of the market, central control suppressed the untidiness of local democracy and civic engagement. Ministers and officials in remote Whitehall gained power; local communities lost it. The service was run… by humane and qualified professionals recruited on merit and working in the public interest….. But

though social citizenship made one of the greatest advances of the century, political citizenship fell back".

The machinations that produced the NHS are documented elsewhere by Klein, Foot, and others but the following key features give song to my miner's canary.

First, Bevan was adamant that Parliament – more specifically the Commons – would design the NHS relying upon its democratic mandate. Bevan used Parliament's power to counter capitalism and the Treasury. While he consulted key players about its features, he refused to negotiate its details with them. The NHS had to be politically accountable so that people knew where to take their representations. He was clear that this accountability related only to those things in the purview of the Minister. He never wished to turn doctors into state employees. But he was aware of the Daily Sketch view that doctors' opposition was the "first effective revolt of the professional class against socialist tyranny".

Second, despite Herbert Morrison, he insisted upon a national system for the hospital component of the service rather than one operated by local authorities, welding the voluntary, teaching and local authority hospitals into one state-owned service within which scarce medical skills could be fairly shared around the country. (Yet in his other role as Minister for Housing he chose local authorities as the vehicle to deliver the much-needed house building programme).

Third, the NHS should be tax borne and free at the point of need. Such was his insistence that he resigned from Government when a growing financial crisis led Gaitskell to impose charges only three years after the NHS came into being.

Finally, he weaved a way through the vested interests of the medical profession and gathered support for his creation, ensuring that just a few months after 5th July 1948 when it came to life, 95% of the population was covered and the vast majority of medical staff worked with it.

Campbell comments that Bevan lived long enough to both experience and despise the consumer society and that he reflected the rise and fall of socialism. For "if anyone could have sold socialism to the Labour Party it would be Bevan"; and insomuch as he failed as a salesman, his life was a failure. It is perhaps ironic that a man who loathed the power of the markets should then be portrayed, by Campbell, as a failed salesman of socialism.

That judgement seems harsh; Bevan realised that state owned assets were essential if Government was to achieve its aims, for where it sought to partner industry it ended up owned by it. Bevan's[11] view of capitalist democracy was that "either poverty will use the power of democracy to win the struggle against property, or else property – in fear of poverty- would destroy democracy". Bevan was thinking especially of the poverty caused by mass unemployment; "it might not be catastrophic unemployment. There might be a slower attrition as there was in Britain before the war, but poverty, **great wealth**, and democracy are ultimately incompatible elements in any society". For Campbell to argue that the socialism that still underpins the NHS has been disowned, or has left British political thought, appears premature.

[11] Bevan, A. I*n Place of Fear*, Simon and Shuster, New York, 1952

One now sees only too starkly what Bevan meant. Sixty years after the founding of the NHS, a failure of international finance has cowed even the greatest free market democracy - forcing it to abandon a historical aversion to statism to save its financial system. Countries have had to underwrite failed banks at the expense of health care, unemployment support, and other public goods. For a trenchant analysis of the threat to democracy caused by market failure look no further than O'Toole's[12] assessment of the Irish banking crisis and the impotence of Eire's Government. Having shown what the NHS owes to two fine Welshmen, and before I turn to the place market forces may have in health care, I next challenge the fashion for using market forces in health to increase efficiency drawing upon lessons from the recent financial crisis.

Part Two: Lessons from the crisis of international finance

Theories of competition assume free markets exist in which consumers know their needs and can choose between many suppliers who compete to get or keep business. Such markets need spare and dynamic capacity to function – which carries a cost. Even if we allow that markets handle the present reasonably well they are less successful at planning for the future. The financial crisis revealed the short-termism that now dominates companies geared to short term corporate gain, and shareholder dividend rather than community value.

Micheal Porter and Mark Kramer[13] recognise that after the financial crisis companies are now under siege as their drive for profit, rather than wider social benefits, is widely questioned. They argue that companies must reconnect business with society and they propose the notion of "shared value" as a route for this. Such an approach would go beyond mere philanthropy and social responsibility. Instead it questions what business does and what it is for. They argue for Governments to nurture this nascent idea. Bevan would smile quietly.

Joseph Stiglitz[14], a senior economist and policy maker with the World Bank notes that while markets are at the heart of every successful economy, they do not work well on their own. Government, as well as the non market sector, has a vital role in countering the market's worst effects but he feels regulation offers little protection; in the international financial crisis regulation failed.

Raghuram Rajan[15] a former Chief Economist at the IMF – hardly a left wing body – and Nouriel Roubini[16], Professor of Economics at New York University's Stern School of Business come to similar conclusions. Rajan's analysis of the financial crisis concludes that the absence of a predicable health safety net (and wider social security) at a time when jobless recoveries appear to be the norm, poses huge challenges for the USA. Government – for the first time – must provide a health care system accessible to all.

Rajan asserts that "financial markets allocate resources to **those most capable of using them, whilst spreading the risks to those most capable of bearing them.** The role of democratic government is to create a legal, regulatory, and supervisory framework within which financial

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[12] O'Toole F. *Enough is Enough*, Faber and Faber, 2010
[13] Porter M. and Kramer M. *The Big Idea, Creating Shared Value*, Harvard Business Review, January-February 2011
[14] Stiglitz J. *Freefall, Free markets and the sinking of the global economy*, Penguin Books 2010
[15] Rajan, R. *Fault Lines*, Princeton University Press, 2010
[16] Roubini M. and Mihm S. *Crisis Economics*, Allen Lane 2010

markets can operate. However, democratic government has other roles, including limiting the most inequitable consequences of the market economy through taxes, subsidies, and safety nets.

Roubini described crises of capitalism as “the norm”, citing the South Sea bubble, the 1630 “tulip mania”, John Law’s Mississippi Company, the American railroad boom of the 1870’s and the recent world wide financial crisis. He notes that the railway and dot com booms created some real assets, whereas the legacy of the recent financial crisis is, mainly, incomplete houses and a huge private sector debt that has been transferred to the public purse. He concludes that “making free markets function better, thus enabling workers to be more flexible and mobile in a global economy where creative destruction will be the norm, requires more not less, government”. But it is government to cope with the social consequences of such destruction, not to avoid it.

Bevan would contest his views that health care exists merely to prop up capitalism and would certainly deny that markets allocate resources to “need” rather than to profit, or that Government should regulate but not own assets.

Vince Cable reminded us a few weeks ago to guard against Adam Smith’s “conspiracy against the public”. All markets tend to monopoly, price rigging, and misbehaviour if left alone. In the last year British Airways and eight other airlines were fined for rigging the air cargo market and we have just heard about the multi- billion pound mis-selling of payment protection.

Tett[17], Lewis[18], Sorkin[19], Cohan[20] and Ward[21] have reviewed the financial crisis and several conclusions consistently emerge. First many financial institutions were not actively managed by their notional owners such as shareholders. Those running risks were not bearing the consequences. Second, any costs of market failure were expected to be passed to others – notably Government. Third, there was imperfect information – especially a failure to understand and properly price the risk of holding complex, novel financial instruments like credit default obligations. Fourth, competitive pressure to deliver short-term profits and shareholder returns, encouraged cheating, discouraged strategic planning, and drove increasingly risky behaviour that was not in shareholder or customer interests. Fifth, financial institutions both called for less regulation and created a shadow banking system deliberately to avoid oversight from regulators.

Sixth, where regulation could not be avoided, regulators became captured. Staff moved regularly between regulators and regulated, often for higher pay. Regulators -fearing the legal political and financial power of those they oversaw - drew back from challenging risky behaviour.
Seventh, the rating agencies meant to be assessing the risk attached to different financial products were cowed into delivering Triple A ratings for products that were complex to the

[17] Tett, G. *Fool’s Gold,* Little Brown, 2009
[18] Lewis, M. *The Big Short*, Allen Lane, 2010
[19] Sorkin, A. *Too Big to Fail*, Penguin, 2010
[20] Cohan, W. *House of Cards*, Penguin 2010
[21] Ward, V. *The Devil’s Casino*, John Wiley and sons, 2010

point where few understood them. Finally, the interwoven nature of international finance rapidly amplified problems arising in the USA so that they infected most of the rest of the world.

The traditional policy response from those arguing for markets in public services is to rely on government regulation rather than government ownership. We see now how regulation of the casino banking culture allowed Western economies to be brought to their knees. Where international big money is involved, as inevitably would be the case with health care, weak regulation is ever likely. Of the three functions in health care- insurer, provider, and regulator – the last is overlooked. Regulating a privatised health care system would be as difficult as regulating world finance, and be costly to the care system itself.

If UK health care was provided by aggressive profit- making companies, or insured by aggressive "for profit" insurers, any regulator would find itself on the back foot in terms of skilled staff, knowledge, and financial fire power when facing the legal and lobbying teams hired by big health conglomerates. It would become the "Fundamentally Supine Authority"[22] of the health world.

Part Three: Market forces and delivering health care?

Health care is a large and growing part of a modern economy. It uses about 5% of the available labour market in Wales; UK now devotes the European average of about 9% of GDP to health care, about 20% of public spending if Government is a major player. In the USA the amount of GDP devoted to health care is about 16% and rising. Health is big business. One understands why the private sector driven by profit rather than value produced casts covetous eyes on publicly funded care systems still operating in European traditions. So let me now turn to the fashionable claim that the collectivist approach to health care is outdated and should be replaced by an approach based upon competition which, under EU law, would open the door to big business.

Greener[23] offers a succinct analysis of key arguments urging caution in the use of market mechanisms in public services. Hunter[24] too challenges the current fashion for their use. He notes the interlocked interests such as the World Bank, international management consultancies, big business and academic bodies that for many years have peddled market-based reform remedies to the world[25]. Such advocates have the traditional American view of free markets and small government which Bevan knew, and to which he provided an alternative. Hunter concludes that market solutions are not a panacea. Instead we should understand the power of good public service combined with clinical governance as a better delivery vehicle for health care. Hunter is supported by others - for example Evans[26] critique of market-style approaches to health. Both have heard the miner's canary. So let us examine how market forces might be used in health care.

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[22] The name used by Private Eye for the Financial Services Authority.

[23] Greener I. *Markets in the Public Sector: When do they work and what do we do when they don't?* Policy and Politics, vol.36, no 1, Policy Press, 2008

[24] Hunter D. The Health Debate, *The Policy Press*, University of Bristol, 2008

[25] For a glimpse of this world see the Observer, front page May 15th 2011, "NHS reforms are a chance to make big profits, says Cameron adviser"; by Daniel Boffey and Toby Helm

[26] Evans R. "*Going for Gold*". *The redistributive agenda behind market based health care reform*. Nuffield Occasional Papers, Health Economics Series No 3, Nuffield Trust, May 1998

Health care and the place of competition

Allyson Pollock's[27] concluding chapter of her onslaught against the privatisation of the NHS notes "the NHS was not an experiment, nor was it a mythical utopia. For more than fifty years it has delivered high quality care for most patients most of the time". What place do the market and competition have in driving up standards and reducing total costs further?

"Competition" can be positive process in health care. It has a place within a publicly owned and run system. Wise use of competitive forces does not necessitate the privatisation of any or all of the components of the care system. Health care facilities, especially NHS ones, should (and often do) strive to achieve the best standards in as many aspects of their care as is appropriate. They should strive to be the first to bring about, but then to share, innovations that benefit patients and others.

In my experience clinical and managerial teams are "competitive", but in the sense that they relish clinical and managerial challenges rather than wishing to drive up corporate profit. Health care professionals are spurred on by providing good care to real individuals within a high quality care environment. The right figure in a profit and loss account is less powerful. In this respect management tools such as such as the National Waiting Times Handbook[28] and Wales' Strategic intent and Direction[29] are fine examples of public sector management driving up the efficiency of provision and improving the planning of health care to produce public good.

Choice too is oft cited as though it was anathema to the NHS. Of course patients should have an informed choice about as many aspects of their care as possible; the date of hospital admission, the type of anaesthetic to be used, which partner to see in primary care, and treatment modes where different possibilities with different trade-offs exist. Choice is part of Dr Julian Tudor Hart's[30] notion of the "co-production of health" by patient and practitioner, drawing on the knowledge of the doctor as a skilled professional and the patient as the expert in his or her own needs.

But "choice" should not be employed so that "good" providers expand and "bad" providers wither. This is not to tolerate poorly performing providers - or insurers/ commissioners, all should offer a competent service. But market- style mechanisms that reduce complex clinical relationships between clinicians, and between clinicians and their patients, to crudely costed procedures, in order to shift financial, human and capital resources between care providers - and therefore between locations and communities over the short and longer term - have no place in the NHS.

Choice can be an unpredictable driver. The late Dr Dani Bevan a GP then Chief Executive in Powys recalled being a newly appointed GP. Pleased with the queues of patients always waiting to see him rather than his partners, he enquired of the receptionist why that was. Expecting her

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[27] Pollock A. et al *NHS plc*, Verso, 2004

[28] *Getting Patients Treated- The Waiting List Action Team Handbook*, Department of Health, August 1999

[29] NHS Directorate, Welsh Health Planning Forum, Strategic Intent and Direction for the NHS in Wales, Welsh Office 1989

[30] Hart J. *The political economy of health care*, The Policy Press, 2006

to laud his training, patient manner, or up-to-date experience, he was chastened when she replied, “They all want to see the fat one who smokes”.

Other drivers are more suited to human organisations seeking to increase health gain for the many, rather than profit for the few. For clinical staff these include delivering evidence- based standards of care within good care pathways from prevention through diagnosis and treatment to aftercare, and updating their care practice as new evidence of what works emerges.

For managers in addition to promoting public sector values there must be an understanding and use of the most efficient and effective blend of inputs, care processes, outputs, and outcomes. Agreed performance standards that relate to the efficient use of staff and estate resources, set within a public service ethos that lauds high quality care delivered in a supportive, “no-blame” culture, and which ensure equity of access, should be published and used. So too should audited standards of practice that place outcomes in the public domain.

Health care and the place of insurance

Insuring against ill health is potentially big business. When care is needed, the ability to pay for it is often reduced. Illness impairs the ability to work or earn high incomes. The very young and the very old often have limited financial means yet make the heaviest demands upon the NHS and few enter this world able to meet the costs of complicated obstetric deliveries and infant diseases. Consumption of health care and the making of financial provision for it occur at different points in time. Thus paying for care requires insurance on a personal, societal, or inter-generational basis and addressing this is shaped by some underlying questions.

First, what kind of insurer is best placed to provide transparent, fair and efficient cover over the 100 years of life that is fast becoming typical? In the continental European tradition insurers might come from not-for- profit religious bodies or trade unions, but both have the weakness of having smaller risk pools and are to a degree self- selecting in the patients they cover. In the USA much insurance has traditionally been an employee benefit increasingly provided to employers by “for profit” insurers, underpinned by a state- based safety net. Ill health impacts adversely upon employment prospects and vice versa. Unpredictable patterns of employment are increasingly a barrier to this form of insurance as Lloyd George and Bevan realised a hundred years ago.

Time does not permit a lengthy discourse on this facet. Suffice it to say that if I was 23 again with a choice of being part of a large risk pool insured through a publicly accountable agency answerable through the political process, or being possibly insured by (several) future employers, or paying AIG or a branch of RBS, I know who I would trust to operate with honesty, judgement, and be around in 2099. Long-term commercial insurance is not compatible with short term profit.

Second, what would be the place of an insurer in determining what services are provided or not? How should insurers allocate funds between profit and the many providers of health care in the form of fees? Should insurers be allowed to insist that clients use only the primary and secondary care services they own, and to specify to clinicians which tests and treatments should be carried out? Can policy holders or employers really judge the offerings of different schemes, both at first cover and in the future?

Modern science further complicates the place of insurance in the care system. Commercial insurers assess risk and make their profit from getting the assessment right. (Bevan described them as "purveyors of the law of averages"). With the coming of genetic screening, predicting risk becomes easier[31] to the point where some individuals, if screened, would be uninsurable on a commercial basis as high premiums and exclusions would make it unworkable. Is it really acceptable for the state is to become the insurer of last resort for only those at highest risk – or should it, as now, remain the insurer of all?

Health care provision and market forces

I now turn to service provision. Patients often know more about their wants than their needs and commercial providers are happy to pander to wants. The essential pre-requisites for efficient markets do not exist as service users are at best only indirect customers having neither the tools nor the time to assess all the health providers in the market place. GPs struggle with that too.

About 50% of acute in- patients[32] are urgent or emergency admissions. If tangled in the wreckage of your Toyota near junction 32 of the M4, you will not be contemplating the relative merits of the University Hospital of Wales or the Princess of Wales Hospital via your iPhone. You may pray that Wales Ambulance service and the non privatised Fire and Rescue service arrive within 8 minutes to deliver you, within the golden hour, to the facility best able to care for you.

In terms of persuading individuals to access services geared to preventing disease or detecting it early, citizens can be reluctant to seek help. Health care bodies opportunistically take their chance to note warning signs of ill health. Jeremy Hallett, former Chief Executive of Gwent Health Authority described a public meeting called to encourage healthier lifestyles. A large lady with cigarette in one hand and a bag of fish and chips in the other rose to interrupt his address: "Oi, we know what's bloody killing us – it's your job to stop it".

Further, what does a contract for primary and secondary care look like? Can it set out the inputs that should go into a particular health care procedure – for example the skills, number, and type of staff to conduct tricky day case surgery? Should it describe the processes that must be followed, for example the combination of drugs, radiotherapy or surgery to be used in different types of cancer treatment? How often must it be revised as new drugs emerge, new techniques are invented and new diseases thrive? Or should it define expected outputs or outcomes? For example should the customer pay if a cancer treatment "fails" and the patient dies when evidence on survival predicts a better outcome?

How long should a provider have to wait for an outcome- based contract to work? The cash flow implications of a hospital waiting five years for its cancer treatment to be successful before it is paid are interesting. And that is before you debate who was responsible for the patient being referred late in the first place thus reducing the chances of success, or the impact of the wider determinants of health.

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[31] Cookson W. *The Gene Hunters, Adventures in the Genome Jungle*, Aurum Press, 1994

[32] Acute here refers to those patients typically seeking general hospital care rather than care in psychiatric hospitals and other facilities such as rehabilitation services. Most patients would be cared for in the medical or surgical sub-specialties.

And over what time period should a contract to run? Could a commissioner let a service-changing 10 year contract requiring, for example, a hospital to transfer some in patient procedures to day case or home settings? For an analysis of the problems with contracting see Harden.[33]

Health Care Systems

Any discussion about market forces in allocating health care resources should note the essential characteristics both of health care systems and markets. We should be on guard when the heirs of Milton Friedman argue that market forces best allocate scarce resources. I stress "system" as too often the health care debate focuses on elective acute hospital care, covering only diagnostic and treatment stages and just a few aspects of the health care process - no coincidence of course, this is where the most profit can be made.

The prevention and aftercare stages are forgotten, but a care system should prevent what can be prevented, should diagnose early what hasn't been prevented, should treat effectively that which has been diagnosed, and, if it must, should care compassionately for those for whom cure is not possible. Managing this continuum using contract mechanisms is to employ a tool that must guide simultaneously a number of interlocking relationships over time. Even where the contract is devised by one intelligence, it asks a lot of a "contract" to ensure coherent services are delivered across the system. Such a challenge is best met by co-operating care professionals than by legalistic bits of paper.

Two benchmarks define a good health care system. First it should increase over time the amount of health gain – the length and the quality of life. Second it should ensure a "good" birth and a "good" death. There is no time now to detail how such benchmarks can be described and measured; suffice it to say that they have been, and should continue to be.

In 2004 the OECD produced comparative health data which, for France (among the most highly rated) Canada (a federal system close to the USA) and the U.K. showed:

	Canada	France	UK	US
Health spending per capita (2002)	$ 2,931	$2,736	$2,160	$5,267
Private share of spending	30%	24%	17%	55%
Life expectancy	79.7	79.2	78.1	77.1
Infant Mort. Per 1,000 Births	5.2	4.5	5.0	6.8

The World Health Organisation (WHO)[34] using a basket of features considered to cover the key elements of an efficient health care system and, out of 191 systems ranked the USA 37th. The

[33] Harden I. *The Contracting State*, Open University Press, 1992

[34] WHO (Geneva), *World Health Organisation Report 2000: Health Systems, improving performance*, WHO 2000

approach was controversial – particularly in the United States - and WHO has not repeated it. Whitman[35] argues that the factors used in that assessment favour publicly funded systems, claiming that such a ranking does not mean that American's get comparatively poor health care, only that they are served by a comparatively inefficient (and highly variable) system because of its high costs. He cites work by Murray[36] which places the UK between 6th and 15th and the USA between 8th and 22nd with planned and collective systems tending to perform well. Recent comparisons show a similar picture[37].

The US relies heavily upon a consumerist approach to health care. Alone among developed countries it has no recognised health care **system.** It does not aspire to ensure universal coverage for its population[38], over 15% of which have no employer-provided, government provided, or privately supplied health cover. Free market mechanisms appear to be less effective than state-funded ones in serving the health needs of society; yet they seem to double the amount of GDP available from which private companies can boost the bottom line.

Privatisation

Before concluding I turn briefly to the use of privisation per se. I draw a distinction between hiring private sector skills to support the NHS, and importing private sector values. Replacing the public service culture with a profit-seeking one as a more efficient means of allocating resources to health care is, at best, unproven.

If it makes service and financial sense for a hospital to lease its X- Ray equipment from the manufacturers rather than to buy it outright so that the private sector shares the risk of technical obsolescence, so be it. If specialist managerial services - I.T., legal advice – can be better provided by the private sector, so be it. But could a big private sector management consultancy really run Prince Charles Hospital Merthyr as a public service better than the best public sector hospital managers? There is a reason why Sir Fred Goodwin was running the Royal Bank of Scotland and not the Co-operative Bank.

Wales

It is fitting that Wales ended the internal market in health when the Labour/ Plaid Cymru coalition signed the 2007 "One Wales" programme for government. Local Health Boards and the NHS Trusts merged to form planning/commissioning and delivery organisations responsible for long term planning and day to day service delivery in primary, secondary and tertiary care. Front line experience is thus more easily fed into the planning and performance management process; the performance management/ commissioning function is challenging of, but supportive to, those providing services. These changes are very much "with the grain" of public and professional opinion in Wales and herald similar changes in local government.

Part Four: The song and the audience

[35] Whitman G. WHO's Fooling Who? *The World Health Organisation's problematic ranking of health care systems,* CATO Institute Briefing Paper, February 2008
[36] Murray C.J. et al, *Overall Health Systems Achievement in 191 Countries, Global Programme on Evidence for Health Policy,* Discussion paper Series No 28, WHO Geneva, Undated
[37] http://www.commonwealthfund.org/Content/News/News-Releases/2007/May/New-U
[38] Sharma M. and Atri A. *Essentials of International Health Care*, Jones and Bartlett, Massachusetts, 2010

I conclude by emphasising the song that I want our Welsh canary to sing and those who might hear its notes.

To politicians
First, political power must continue to shape the health care system if it is to remain available to all. A political process is the best route through which service priorities and service failures can be openly addressed and over long periods. Needed services must take precedence over profitable services. As devolution and Europe increasingly impact upon health, politicians in Cardiff Bay, and especially Brussels / Strasbourg must join the debate if Bevan's plea for democracy to address property if poverty is to be harnessed is to be heeded. Local government too must recognise and play its part in delivering health.

Second, Lloyd George and Bevan brought their experience of life into Parliament and used it when delivering for their people. Both skilfully managed the special pleading they encountered. To what use would they have put focus groups and political advisors? Today's politicians must have, and draw upon, broad life experiences when deciding policy.

Third, national public ownership of capital assets is necessary if Government is to ensure care services of competent standard for all localities equitably across the U.K. Ownership serves another purpose; it retains levers of influence to regulate effectively the health care system as a whole. Politicians should challenge conventional wisdom - displayed in the debate about the nation's forests - that government cannot both regulate and provide particular services. The public sector must retain knowledge and market clout to inform and empower its regulatory function, and to be the provider of last resort.

Fourth, politicians should articulate what most people sense – that health care is funded by us all contributing, by agreement, to a risk sharing, national insurance fund which provides predictable and efficient funding for one of the most effective and efficient health services in the world. Here we really are "all in this together". May citizens cherish their NHS and use it responsibly.

Fifth, national planning and allocative processes by which GP and consultant resources are spread equitably throughout the nation might be extended to encompass other professions, for example nurses in critical care areas and currently "shortage" skills in remedial therapies.

To clinicians
There are advantages in working in a professionally collegiate environment powered by public investment to meet need, rather than in an environment powered by profit. This offers a setting where skills can be honed, deployed, and enhanced. Hospital staff that experienced the war time Emergency Hospital Service saw the benefits of marrying professionalism with public service. May Dr Cameron become more typical than mythical. May clinicians welcome scrutiny where it is well founded, evidence driven, and part of a professional process of continuous improvement.

To managers
NHS managers should recognise the responsibility they carry and so husband the resources of the service that it cannot be accused of complacency, inefficiency, or indifference. They should be the first to see poor performance, and be intolerant of it. They must find new ways of

speaking truth unto power so that if politicians and clinicians serve the NHS poorly, they are so advised. With clinical staff, they must be proactive in leading and developing the service from within rather than meekly accepting new organisational nostrums repeatedly offered from without.

Academia
If the NHS is to be founded upon good evidence of best clinical and organisational practice, the clinical and managerial capacity of academia and its wider research capability must underpin, nurture and challenge the NHS.

To the public
Finally, the public should judge the NHS by their experience of it, relying neither on the Sun nor the latest (unpublished but leaked) satisfaction survey to colour their view. But if they want one gauge of value for money, why not ask an insurance company for a quote for cover for all that the NHS provides?

The miners canary has been caged long enough, open the door, let it fly free and sing.