

Dismantling the Health Service

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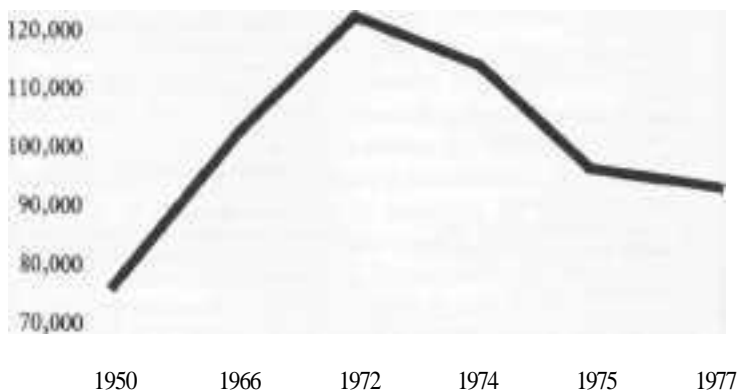
If the NHS is the 'jewel in Labour's Crown' it is also the great test of Conservatism. Should the National Health Service be dismantled and replaced by some sort of market-oriented medicine, the Conservatives will have achieved two things: the destruction of the most politically important of all the institutions of the Welfare State; and convincing proof of the labour movement's fundamental inability to dominate social development.

The present Conservative government may well fail this test, but there is no guarantee of this, nor any reason why a successor might not pass. The politics of health may be a relatively unknown field to Conservatism, but the labour movement which created the present NHS has little understanding of the issues either. However guarded the Cabinet may be about its capacity to dismantle socialised medicine, its immediate opponents are so weakened by reformist and Fabian thought and practice that the political initiative still lies firmly with the Right. Our fortune is that the Right does not know how to proceed, is unsure of its ground, and fears an overwhelmingly hostile response to any attempt to destroy the National Health Service. By force of circumstance, rather than force of opposition, the Government must move slowly and quietly if it wants to replace our present system of health care with some variety of private medicine.

The goal of the present Government is clear; they wish to see market forces dominate the development of health care as far as possible. Within the ideology of Conservatism, responsibility for health is to become personal rather than social.^{1,2}

Such a grand design must overcome substantial obstacles: the small size of the existing private medical sector, and its financial instability; the scope of the service provided by the NHS, and the pervasiveness of its institutions; the size of the NHS labour force and its influence.

Figure 1
Patients treated in pay beds in England and Wales



Source: Michael Lee, *Private and National Health Services*, London, Policy Studies Institute, 1978

The factors favouring the Conservative attack are less impressive: the presence of a willing ally in a section (potentially a majority) of the medical profession; the deterioration in the standards of care given by the NHS; and the precedent created by the long-tolerated parasitism practised by the drugs industry.

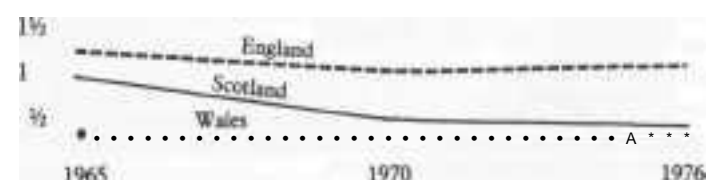
The Conservative strategy, as far as it can be assessed, is directed at stabilising the private sector, diminishing the scope of NHS activity through cuts and cash limits, and shifting certain (profitable) areas of health care into the private sector. The Government will take a 'firm line' on industrial relations within the NHS, aiming to weaken trade unionism and solidarity generally by limiting trade union rights and turning one group of health workers against another. The medical profession (and professions like nursing) will be given more influence in planning development and allocating resources, and doctors will be encouraged to act as the link between private and public services. Finally, declining standards in NHS care that have been caused by cuts imposed by this (and previous) governments will be used as evidence of the failure of state intervention and the superiority of private enterprise.

THE OBSTACLES TO CONSERVATIVE STRATEGY

There is no part of the welfare state that reaches more people of such varied ages, races and social classes within British society than the health service. The client-groups for public housing, public education, personal social services, welfare benefits, and even public transport are restricted by comparison with the population in contact with the health service. Each day of the year an average of 100,000 people attend hospital accident and emergency departments. Each year there are about nine million *new* attendances at out-patient clinics. Each year each person makes an average of three visits to their general practitioner.³ Those people exclude the contacts people have with maternity services, health visitors, district nurses and clinic doctors. In terms of volume of contact between people and institutions, the NHS is a pervasive and enormous influence. Its provision of services free at the time of need (even when limited by charges), of a comprehensive range of services (however badly distributed), and of its continuity of care (however inefficient) make it a living and accepted example of a socialist institution.

An important aspect of the acceptability of socialised health care to a wide cross-section of social classes is that it is an open-access system, with no financial barrier to consultation with a health worker (whether the worker be doctor, nurse, health visitor, midwife) although there may be such a barrier to treatment (eg, prescription charges).⁴ Such open access is crucial when the whole realm of illness and health is such a mystery, such an unknown issue, for everyone. The inability of an individual accurately and realistically to predict his/her future needs for medical care makes insurance-based health services very inadequate. None of the private medical insurance schemes⁵ can ensure against all eventualities; a health service financed out of general taxation and catering for the whole population can cope with almost all medical requirements, even if it cannot always accommodate the

Figure 2
Pay beds as a percentage of total beds in NHS hospitals



Source: *Report of the Royal Commission on the NHS, 1979*

scale of need.⁶ All systems of health care that depend on individuals making decisions about how to use their personal resources fail because an informed decision about future need is impossible.⁷

Finally, the rivals to socialised health care are unimpressive. Strictly private medicine, in the form of private hospitals and pay beds in NHS hospitals has been small scale since the formation of the NHS (Tables 1 and 2).

Not only has the scale of private hospital in-patient care been small, but its scope has been narrow and largely restricted to non-urgent surgery and investigation of non-urgent problems. There is little financial gain to be made from long-term care, particularly when it involves those whose income is reduced by their disability (the mentally ill and the elderly). Even the chain of privately run nursing homes for the elderly depend on an NHS subsidy, with more than 40% of the 27,000 nursing home places being occupied by people referred from and paid for by the NHS.⁸

The private insurance groups

Private medicine conducted outside hospitals, in consulting rooms and GP's surgeries, is in a larger scale, yet still cannot match the enormous scale and range of NHS-population contact. The financial rewards of private medicine are so small that it has remained a tiny proportion of general practitioners' incomes⁹, whilst the private practice enjoyed by London specialists in Harley and Wimpole Streets has depended on a massive influx of overseas patients to compensate for a decline in the local market in the mid-seventies.¹⁰ The early 1970s demonstrated the vulnerability of private medicine to general economic change. As personal incomes were squeezed, at the beginning of the economic crisis, the number of individual subscribers to private medical insurance fell. Doctors in private practice responded by cultivating an overseas clientele. The insurance schemes turned to group enrolment as an answer, presenting private medical insurance as a fringe benefit for companies to give their middle-management personnel or offer to their workforce as a part of wage negotiations. The overseas market proved unreliable, as the oil-producing states that sent their citizens to London for medical attention were found to be quick to complain about poor service, and slow to pay. On the other hand the group enrolment schemes of the insurance schemes were effective, producing a 25% increase in subscription between 1971 and 1979, despite the slump in membership in the early seventies. Although the private medical sector recovered from this period of shrinking markets, the instability it demonstrated still haunts the insurance schemes.

CONSERVATIVE ADVANTAGES

The greatest Tory ally in any strategy to promote private medicine at the expense of public services is the medical profession. Whilst only a section of the profession is openly in favour of a partly or totally private health service, and the majority of doctors probably accept the value of the present NHS, the whole definition and conduct of professionalism in medicine leans towards paying for health care. The organisation of the medical profession has evolved from a market-place transaction between patient and doctor over a package of commodities — medical advice and medical treatment. The relationship between doctor and patient, provider and customer, is the central feature of the 'liberal professionalism' of medicine. All the other elements of medical professionalism flow from this source: 'clinical freedom'; 'the doctor-patient relationship'; 'confidentiality'; consultant power over the distribution and provision of services, and the 'individual contractor status' of general practitioners. The right to charge a fee for services (or to waive that fee if so desired) is only one part of the ideology of medicine. State intervention in health care has

altered this ideology to some extent by making hospital doctors salaried staff and by bringing general practitioners into a contractual relationship with the NHS. The significance of private practice has become marginal because of this intervention, but the ideology

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remains intact. Private medicine is *defended as a principle* because of its overall significance to medical professionalism, not because of its actual relevance to the work of the majority of doctors. With such a profession at the centre of power in health care, any government actively supporting the growth of private medicine would be acting within the existing ideological framework of medicine. Even if only a minority of the profession actively support the resurgence of private practice, the majority will find that resurgence compatible with their conception of medicine, even if not desirable. This is the Government's greatest asset.

The individuality within medical professionalism has serious consequences for health service activity. Distribution of services and facilities may be determined according to the needs of doctors rather than the requirements of the population, with the most needy areas, classes and individuals getting the least.¹¹ Medical care may be poorly co-ordinated and unplanned (particularly in general practice), with consequent wastage of time, money and resources. And consumer demand may be allowed to take priority over forward planning and



¹ Jenkin's interview with the magazine *Director*.

² Vaughan's letter to the BMA, July 1979.

³ Royal Commission on the NHS Report, pp25-126.

⁴ There are some financial barriers to consultation where consultation almost invariably leads to treatment — chiropody and dentistry are examples. The Government intended to introduce charges for eye testing despite the opposition of the opticians, but has been forced by strong pressure to remove this proposal from the Health Services Bill.

⁵ The major organisations are British United Provident Association (BUPA), with 73% of the privately insured, and Private Patients Plan (PPP) which has 24%. Nine other small schemes cover the remainder. A detailed account of how the insurance schemes work can be found in *In Defence of the NHS*, Radical Statistics Pamphlet, pp21-22.

⁶ An example is renal dialysis; facilities are currently insufficient to meet need, but technically need can be met.

⁷ B Abel Smith, *Value for money in health services*, 1976.

⁸ *Observer*, Sunday July 8th, 1979.

⁹ Taking the GP population as a whole; some are very involved in private medicine, particularly in inner-London.

¹⁰ Ilman, *General Practitioner*, Dec 15th, 1978.

¹¹ J Tudor Hart, 'Inverse Care Law', *Lancet*, 1971.

analysis of needs. These are the consequences of the market-orientation of the medical profession, even 70 years after the 1911 Insurance Act initiated state intervention in health care. The promotion of private medicine will lead to the amplification of all these complementary problems.

This does not make a case for an anti-professional attitude to health care. There is no doubt that medical professionalism as it now stands is important to medical care, and relevant to the future. The nature of personal contacts between health workers (not just doctors) and people consulting them is crucial to the maintenance of health and the management of illness. Some system of decision-making involving those with practical experience is essential, but the balance of clinical, planning, service and consumer views and skills is not going to be found in the present combination of professionals and businessmen¹² on health authorities. An alternative view of medicine— as an applied social science dealing with definable problems within a whole population — exists within much of the activity of the NHS, amongst

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planners and managers as much as amongst doctors, but it has not yet evolved its own ethic or its own political institutions. The powerful conservative wing of the medical profession will do much to prevent such evolution, for 'liberal professionalism', itself a special form of Conservative 'freedom', is the jewel in medicine's crown.

The impact of cuts

Private medicine, if it is to grow, will need opportunities to expand and justifications for doing so. The successive waves of cuts and cash-limits applied to NHS spending by both Labour and Conservative governments have meant a reduction in services, facilities and staff, and compensatory attempts to increase efficiency and 'productivity' by demanding more of staff and patients alike. The extension of waiting lists for surgery, and waiting times for out-patient appointments, plus the limitations on time for communication and explanation of problems and solutions, are propaganda for the private sector, which can step in and offer its own solutions at a price. As the economic decline proceeds and problems of housing, transport and employment increase, we can expect an increase in the incidence of major physical and mental disorders and a consequent increase in the demands made on health services. There is some evidence that the level of employment has a *direct* effect on patterns of heart disease, overall death rates, admissions to mental hospitals, infant mortality and suicide rates¹³. And there is little doubt that unemployment and housing difficulties are major contributors to serious and widespread psychological disturbance.^{14,15}

Of course the population that bears the full burden of the crisis will not be in much of a position to take up private medical services, for low income will be one of its major problems. Any expansion of the private sector will come because the increasing demand on the NHS will preoccupy the service, particularly as cuts in expenditure reduce the service capacity to respond to demand. The pressure on staff will increase, and the temptations of opting out of the NHS and into the private sector (already noticeable amongst nurses working part-time) will grow. The deterioration in standards and speed of care will also act as an incentive for those not hit hard by the economic crisis to seek alternative forms of health care. In the cities, where health services are costly to run and subject to pruning, hospital closures will deprive local populations of small, nearby (if outdated) District General

Hospitals and concentrate facilities on larger, often Teaching, Hospitals¹⁶. As a result both buildings and staff previously available to the NHS will come onto the market. Over a period of time the private sector may obtain a larger potential clientele¹⁷, trained staff of all categories, and even ready-made facilities.¹⁸

The drugs industry

The role of market forces in determining the development of health care is already well-established in Britain outside the private medicine field. The pharmaceutical industries have an influence over medical practice that distorts medicine by blatantly presenting chemical 'solutions' to social problems, encourages over-prescribing and multiple prescribing with the attendant risks of potentially dangerous drug combinations, and diverts finance from other areas of health care^{19,20}. Massive advertising campaigns directed at doctors who insist that they know exactly what they are doing ('clinical freedom') despite evidence to the contrary set patterns of drug use in the population that are as much a reflection of the profit needs of a monopoly industry as they are of the medical needs of the ill. Postgraduate education of doctors, particularly general practitioners, is heavily dependent on the drug companies, through their visiting representatives, while their advertising revenue keeps medical journals going, and major subsidies given for conferences and meetings. This co-operation between the profession and one facet of monopoly capitalism, despite the evident disadvantages of it to the population and the health service, is a warning that a similar relationship — between doctors and large private medical corporations — would have a precedent.

CONSERVATIVE TACTICS AND STRATEGY

Thatcher's Cabinet does not have one single tactical line for shifting medical care back into the market. On the contrary, it has three tactics that may be pursued in isolation or independently, according to circumstances. The first tactic is to aim for minimal change by encouraging individual consultants to undertake private practice inside the NHS and letting the private insurance schemes look after themselves without too much assistance from the government. The second tactic leads to the creation of two health services, one public and one private, working in parallel and in conjunction and finding their own balance of influence and responsibility for provision of care. The third tactic aims for maximum change — replacement of the National Health Service with an insurance-based system like those operating in the USA or in parts of West Europe.

The tactic of minimum change has almost been achieved already, with the abolition of the Health Services Board that phased out pay beds under Labour, and the suggestion that a limited re-investment of paybeds was possible in certain areas²¹. Consultant contracts are being revised to permit all consultants in the NHS to undertake private practice, not just those consultants with part-time contracts as now. The general character of this Government's commitment to restructuring the whole of society and removing the features of socialism introduced by Labour governments suggest that they will want more than the first tactic can give. Nor will the medical insurance schemes happily abandon their chances of supported growth, as they made clear in talking of the need to 're-educate' Conservative politicians about private medicine in an internal discussion document leaked by the Communist Party in 1979.²²

The tactic of maximum change

The tactic of maximum change is a big step, even for the radical Right, for it could antagonise many Conservative voters aware of the NHS's value and fearful of the financial implications of private care *imposed*



upon them rather than chosen. It would also embroil the Government in conflicts with the million strong workforce of the NHS whose jobs could be threatened by such an enormous change in health care, including the medical lobby that wants to keep private medicine under its control, inside the NHS. Finally, it would mean the creation of a service that would probably be more bureaucratic and more expensive (or rather, less cost effective) than the public service. Worse still, it would demand direct government subsidy, since a proportion of the population would not be able to afford medical insurance, either through poverty or through disability that was uninsurable. This group of people would need some kind of provision, however shoddy, and the cost of that would have to be borne primarily by the government (although charities could be recruited to obtain some of the revenue). The most important point about medical insurance systems is that they *must* exclude a proportion of the population; an insurance system that included everybody would just be a form of specially-earmarked tax on income, and new (and cumbersome) forms of taxation are not a part of the Government's plans^{23,24}. To adopt an insurance system, therefore, would mean that the Conservatives were prepared for a short-term political conflict and in the long-term were prepared to accept the social and economic consequences of excluding a section of the population from health care. There is some evidence that the Cabinet is aware that such an approach would produce the kind of problems now experienced in the American health system. Nevertheless a feasibility study of insurance systems is under way in the DHSS.²⁵

The tactic of choice

The tactic of parallel health services is the Government's tactic of choice. It runs contrary to Conservative thinking in some senses, for it implies a long-term subsidy from the public sector to the private sector (which can only provide a marginal service from its own resources, to the eternal shame of the advocates of private enterprise). Equally, Government boasts about direct, honest and fearless policies could not be applied to an approach that is piecemeal, pragmatic and sometimes covert. Such objections are unlikely to worry the Cabinet, however, when the prize is Labour's jewel.

The mechanics of this are three-fold. Firstly, the cuts in expenditure and the imposition of cash limits on health Authorities

that were begun by Labour governments are being continued, and intensified, to force a 'rationalisation' of health services. As outlined above this will have consequences for the extent and quality of medical care that in turn will tip the balance in favour of private services, both from the point of view of the consumer and the service workers. Secondly, the structure of the NHS is being re-organised to push responsibility for provision of services away from central authorities (like the DHSS and planners and administrators at Regional and Area level) towards the 'grass roots'. Management methods are also being re-organised so that personal accountability of administrators can replace the collective responsibility of the present complex committee structure.

These structural reforms, presented in a consultation document called *Patients First*, will have dramatic effects on the NHS. The planned decentralisation of responsibility is dressed up as being democratic, yet is the opposite. The proposed new District Health Authorities will have fewer representatives from local government (or any other lay source), and fewer non-professional staff representatives than the present Area Health Authorities. They will probably have

¹²J Robson, 'NHS Inc?', *International Journal of Health Services*, 1974.

¹³Harvey Brenner, 'Mortality and the National Economy', *Lancet*, 1979, pp568-573.

¹⁴Len Fagin, 'The psychology of unemployment', *Medicine in Society*, Vol 3, No 1, 1978.

¹⁵G Brown and T Harris, *The Social Origins of Depression*, Tavistock, 1979.

¹⁶J Yudkin, *British Medical Journal*, Vol 2, p!212, 1978.

¹⁷BUPA estimates 8 million potential subscribers and actually has about 2 million.

¹⁸Witness the proposals to save the Elizabeth Garrett Anderson Hospital for Women through private involvement.

¹⁹*The Pharmaceutical Industry: a discussion document for the labour movement*, Labour Party, 1976.

²⁰J Robson, *Take a Pill: the drug industry private or public*, Communist Party pamphlet, 1974.

²¹See footnote 2.

²²'Private medical insurance in a changing political environment', *Medicine in Society*, Vol 4, No 4, 1979.

²³See footnote 7.

²⁴P Torrins, *Lancet*, Jan 5th, 1980.

²⁵*Hansard*, Jan 23rd, 1980.

more medical representatives, however, reversing the trend towards displacement of medical influence that the 1974 re-organisation began. The new Authorities will be based upon existing hospitals (themselves distributed in an unplanned way) and community-based services will be organised around them, threatening the intended community orientation of health service growth that has been aimed for over the last decade. The very title *Patients First* expresses a vision of health care as dealing with *patients* almost exclusively, and not with people seeking to maintain health. This vision is essentially a doctor's vision of disease, and the idea of shifting influence further back towards the medical profession and concentrating it on hospitals confirms the one-sidedness of Conservative thinking about health care. Even the new management proposals contribute to this narrowing of NHS functions, for consensus management based on consultation with staff (however inadequate in method and uninspiring in practice) is more democratic than the command structure of the old Hospital Management Boards and Hospital

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Secretaries that the Conservatives seek to re-create under new names. Planning future development is going to become the responsibility of administrators primarily concerned with day-to-day organisation and increasingly influenced by the reinforced medical voices on the management committees.

The role of the medical profession in controlling health services will become increasingly important. This is the overall objective for the Government precisely because the medical profession has a complex and traditional relationship with private medicine in particular and monopoly capitalism in general. As a supplementary objective the Government is intervening in industrial relations with new provisions for dealing with disputes in the NHS. These provisions include organisation of voluntary labour and use of outside services (catering, laundry and laboratory facilities) if NHS services are disrupted by industrial action.²⁶

Government steps

The Government's perspective for change was outlined in a letter from Health Minister Gerard Vaughan to the Secretary of the British Medical Association in July 1979. The letter described the co-operative growth of private and public hospital facilities at a local level, listing a number of practical steps that could be taken:

- 1 Advance notification of all significant private hospital development plans should be made to the relevant NHS Health Authority.
- 2 Local consultation between Health Authorities and private medical interests to ensure orderly and effective development of health services. Disagreements would be settled by the Secretary of State for Health and Social Services.
- 3 Increased use of contractual arrangements (working in both directions) for the joint provision of services, sharing of some staff, collaboration in research and in staff training.

The letter pointed out that most of these suggestions could be implemented without legislative provision, but that extra powers would be needed to permit private hospitals to provide services for the NHS and to take part in collaborative projects. Enabling legislation that would give such powers is currently under review in Parliamentary Committee — the Health Services Bill.

The end result of such changes will depend upon future expenditure on public health services. If the erosion of the NHS is halted and increased funding provided, a parallel structure of private

services would lose its opportunities for growth and face genuine competition. On past evidence it would not be able to compete and would maintain its marginal position, but would achieve the minimum option described above. If, on the other hand, public expenditure on health is further reduced, and the demand for private medicine increases enough to warrant large-scale capital investment

The effect of reformism has been to deny that the NHS is an area of class conflict

in new facilities, the private sector could grow in areas where substantial affluence persists despite the economic crisis. Under these circumstances the maximum option— largely insurance-based health care — may evolve in some parts of the country whilst public services predominate in others. At present the distribution of private medical practice is the same as the distribution of wealth, both socially and geographically, and we may see a phase in the development of health care when the South East has a different system of health service provision than, say, North East or North West England. The prospects of such growth clearly excite the medical insurance schemes. The Chief Executive of BUPA, Derek Dammerel, wrote an article in a medical newspaper in January 1979 that expressed this excitement directly:

'In the Republic of Ireland they have an NHS, but quite deliberately in recent years have encouraged the growth of voluntary health insurance. When I say encouraged they have given tax concessions, subsidise those who go into private or semi-private beds and indeed, encourage a private facility to be built alongside the state system and to share in the expensive equipment in every way possible.' — *Pulse*, January 27th, 1979, p!7.

The prospect of parallel health services, then, is an attractive one for the vested interests concerned. In the short term it will subsidise the private sector. And in the long term, it could provide the springboard for replacement of the National Health Service by an insurance-based system.

THE LEFT AND THE POLITICS OF HEALTH

At first glance the Left and the labour movement generally have become increasingly concerned about political issues arising from health care over the last decade. The unionisation of health workers, the shift of professional organisations towards or even into the trade union movement, the disputes around pay beds, the resistance to the cuts, the development of a health students' movement, the appearance of agitational magazines and newspapers in hospitals and amongst unionists, the flurry of pamphlets and books, all of these suggest an intense interest and response to the politics of health. The impression is false, just as the measurement of an organisation's activity in terms of leaflets distributed or meetings held gives a false impression of its impact. If we look at the results of this activity the picture (apart from improvements in wages and salaries) is not impressive:

1 Trade union involvement in management of health services has developed up to a point, but persistent conflicts with professional organisations plus lack of trained cadres prevent full penetration of trade unionists into the administration of a public industry with more than a million employees.

2 Community-based organisations concerned with health issues have arisen from outside the labour movement more often than not. Trades councils with health subcommittees are the exception, not the rule, and the whole range of single-issue voluntary organisations like MIND (mental health), the Spastics Society, Age Concern and so on are outside the influence of the labour movement. Community Health

Councils have shown themselves to be effective organisers of resistance to cuts as well as careful assessors of the standards of service in many areas, but trade union input into them is patchy and the only political party that has shown serious interest in them is the Conservative Party — which wants them abolished. The happy exception to this pattern is the relationship between the labour movement and the campaigns to defend the 1967 Abortion Law.

3 The level of analysis of specific problems — like what to do with the pharmaceutical companies — is low, with Labour Party policy being caught (still) in mixed-economy ideas and partial reforms of price structure and advertising restrictions. Issues of management, administration and planning are outside the Left's sphere of politics, and there is a general feeling (most marked on the far left) that issues like private practice and prescription charges are worth more attention than the more protracted struggle within the institutions of health care.

As a consequence the labour movement does not have a perspective for the development of health care, even though individuals within the movement do (or think they do). The slogan 'Defend and extend the NHS' fails because neither adequate defence nor practical extension are possible for a movement that has left all such complexities to 'experts' without watching carefully what they do, and interfering in their activity when necessary.

Two key problems

If the labour movement is to stop the Conservatives achieving their goal of restructuring the NHS, two problems have to be dealt with. The first entails bringing the politics of health into the mainstream of labour movement activity, by using organisations like the Socialist Medical Association and the Medical Practitioners Union more as autonomous campaigning bodies and less as specialist adjuncts to the broader movement. The second requires the right issues to be selected and campaigned around, through appropriate forms of organisation. Both problems will be difficult to solve, given that in the post-war retreat of socialist ideas and organisations, the labour movement surrendered its weakest areas first. Health care was, and still is, one of those weak areas. Paradoxically the most significant creation of post-war social democracy is also its area of greatest ideological and organisational weakness. The effect of reformism has been to deny that the NHS is an area of class conflict, choosing instead to pose efficient administration against professional influence. The political significance of the medical profession, the nature of its 'professionalism', and the need to organise politically within it, have all been underestimated and neglected. Concern over policy issues has been presented as a special matter and taken out of the normal range of labour movement consideration. The political dominance of the right in the Labour Party has inflicted this on the movement as a whole, and a Communist Party pushed to the margins of politics has had little choice but to accept this.

The first problem is potentially soluble. Renewal of the Socialist Medical Association, reorganisation of its branches and a return to active campaigning within the labour movement, are all occurring. Whether the SMA can ultimately co-ordinate NHS trade unionists, CLPs, Community Health Councils, trades councils and socialist and radical professionals remains to be seen. But given careful attention by the Left there is no reason why it should not do so.

Taking the politics of the labour movement into the medical profession's structure is a more difficult problem. The Medical Practitioners Union is the only vehicle available to the movement, but receives insufficient priority within trade unionism and is short of resources. Given adequate support it could take a spectrum of labour movement policies into the organisations of the medical profession and engage the Right on its own ground. To do that the MPU has to be

freed from a form of left sectarianism that is prevalent within the labour movement. The assessment of doctors as a group being 'the class enemy' means that organisations like the MPU are seen as havens for 'class traitors' from medicine who can be drawn towards the labour movement. There is no conception of mass organisations that could drive a wedge into the medical profession. Combating this approach requires conscious effort in trade unions and political parties from the top levels of leadership down to cadre level — the kind of effort where Communist Party initiatives may be decisive.

Priority issues

The problem of selecting priority issues in health care and campaigning around them is a lesser one for the labour movement. The wide range of single-issue and broad initiatives by small, local organisations gives scope for labour movement action, even though most of these campaigns have arisen outside the traditional working-class organisations. The prospect of winning new services or improving existing ones suggests that campaigns around community-based and preventative medical services should be pursued: in defence of existing child care clinics and screening programmes, and for their extension to areas lacking them; to establish well-woman clinics and day-care abortion units; and for experimental salaried general practitioner services in the cities. The pressure in favour of private medical insurance is so great that a labour movement campaign against insurance schemes is imperative. In the first instance such a campaign must be aimed at the most vulnerable sections of the working population, to whom insurance schemes may appear attractive. In the longer term, the attack on private medicine needs projecting into the NHS structure (to minimise or undermine local relationships with private medicine) and the medical profession

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(to neutralise the Tory's major ally, if at all possible). Finally, the extension of trade union and community opinion into NHS administration at all levels is a high priority. Correction of the imbalance between professional interests on the one hand and non-professional and lay views on the other could tip the balance of power at local level, in favour of rational planning to meet local needs. Co-ordinated intervention in the day-to-day activity of the NHS by progressive professionals, trade unionists and community organisations could have an increasing impact on Health Authority functioning. Such intervention is feasible now in some areas where the component forces already exist (if only in embryo) in anti-cut campaigns and health-service sub-committees of trades councils, and could be extended to other, mainly industrial, areas where organisation has a strong basis.

If this counter-attack can be launched, it could halt Conservative plans to dismantle the NHS, if only by drawing-out the political conflicts that the Government already fears could be unduly prolonged. Could a stalemate over health service reform throw wider policy issues into question, and blunt the Tory ideological offensive? And could a socialist renewal, even if a decade or more distant, spring from the campaigns to preserve the National Health Service? How ironic it would be if the Left found the spearhead of anti-Conservatism through the hesitations and reservations of an otherwise strident Government, and not through its own 'scientific' analyses! D

²⁶DHSS circular, Dec 1979.