

Liberty's Command: Liberal Ideology, the Mixed Economy and the British Welfare State

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Introduction

The immediate period after the Second World War and lasting until the 1960s was an unusual one for capitalism. It was characterised not only by steady economic growth, not to be matched since, but also by a cross-party political consensus on the desirability of a strong safety net in the form of a welfare state. The period has often been termed 'welfare state capitalism' by commentators. It was an era that came to a fairly abrupt end in the mid-1970s. If the oil crisis of that time provided a marker, the election of Margaret Thatcher in 1979 was to usher in a new phase of what we might call 'financial capitalism'. In this chapter, I trace the origins and course of this transition up to and including the global financial crash of 2008–9. It was a transition that was as cultural as it was structural, leading to new and exacerbated forms of individualism and fragmentation as well as material and social inequality. The generalised commitment to the provision of state welfare gave way to a ubiquitous, near-global ideology of neoliberalism.

I start with a necessarily abbreviated consideration of the history of the British welfare state in general and the emergence of the National Health Service (NHS) in particular. The present, we need to remind ourselves, involves both past and future, the former being the present's precursor, the latter its vision of what is to come.

Origins of the Welfare State and NHS

In fact, Britain was slow off the mark with welfare provision. The first direct engagement was via the National Health Insurance Act of 1911. Prompted by concerns about high rates of work absenteeism and lack of fitness for war duty among working men, this Act protected a segment of the male working class from the costs of sickness. It drew contributions from the state, employers and employees, and it entitled beneficiaries to free primary care by an approved panel doctor (a local GP) and to a sum to compensate for loss of earning power due to sickness. Better paid employees, women, children and older people were excluded and had either to choose fee-for-service primary as well as secondary health care or resort to a limited and fragmented system of 'public' (state-funded) or 'voluntary' (charitable) care. The Act covered 27 per cent of the population in 1911, and this had only expanded to 45 per cent by the beginning of the Second World War.

Pressure, most notably from the expanding middle class, grew during the 1920s and 1930s to extend the reach of health care services. An overhaul eventually took place during the Second World War, evolving out of Beveridge's (1942) painstaking blueprint for an all-out assault on the 'five giants' standing in the way of social progress: Want, Disease, Ignorance, Squalor and Idleness. In retrospect, it seems clear that this initiative marked

the end of liberal capitalism, the consolidation and expansion of state intervention and the commencement of welfare state capitalism. The Beveridge Report incorporated plans for a National Health Service. The displacement of Churchill's wartime government by Attlee's Labour Party in 1945 not only realised the concept of a welfare state but, following the National Health Service (NHS) Act of 1946 – a skilled piece of midwifery by Health Minister Aneurin Bevan – the birth of the NHS in 1948. The NHS was based on the principles of collectivism, comprehensiveness, universalism and equality (to which should be added professional autonomy). The state was thereafter committed to offer primary and secondary care, free at the point of service for anyone in need. These services were to be funded almost exclusively out of central taxation.

The 1946 Act was a compromise with history and the medical profession. GPs avoided what they saw as salaried control and became independent contractors paid capitation fees based on the number of patients on their books; the prestigious teaching hospitals won a substantial degree of autonomy; and GPs and, more significantly, hospital consultants won the 'right' to continue to treat patients privately. The survival of private practice has been judged important: 'the NHS was weakened by the fact that the nation's most wealthy and private citizens were not compelled to use it themselves and by the diluted commitment of those clinicians who provided treatment to them.'¹

Evolution of the Welfare State and the NHS to 2010

It is not possible in this short contribution to do justice to the development of the post-Second World War welfare state in Britain, but a brief mention of changes in social security, housing and education is important. The terms 'welfare' and 'social security' are often treated as synonyms, and state interventions in welfare provision in Britain date back to the introduction of the Poor Law (and Work Houses) in 1536. What is known as the 'welfare state', however, has its origins in the Beveridge Report. Beveridge recommended a national, compulsory flat-rate insurance that combined health care, unemployment and retirement benefits. This led to the passing of the National Assistance Act (1948), which saw the formal ending of the Poor Law; the National Insurance Act (1946); and the National Insurance (Industrial Injuries) Act (1946). There have been many changes to this legislative package since, most having the character of piecemeal social engineering, but there has been a growing tendency towards cutting welfare benefits in post-1970s financial capitalism. By 2010, expenditure on state pensions amounted to 45 per cent of the total welfare bill, with housing benefit coming a distant second at 11 per cent. Then came the decade of austerity and much more savage cuts.

As far as housing is concerned, the average home in 1960 cost £2,507, while by 2010 this had risen to £162,085. Incomes failed to keep up with property prices everywhere, although there were strong regional differences. The type of housing also changed dramatically. Between 1945 and 1964, 41 per cent of all properties built were semi-detached, but after 1980 this fell to 15 per cent. The number of bungalows also declined. Detached houses, however, which were 10 per cent of stock built between 1945 and 1964, accounted for 36 per cent of new builds after 1980. The peak year for house building was in 1968. Private renting made a comeback after years of decline, reflecting a growth in buy-to-let investing, while home ownership slipped back from a peak of 70 per cent in 2004 to 68 per cent by 2010. Thatcher's right-to-buy legislation meant that the number of people renting from their local council fell from 33 per cent in 1961 to 14 per cent in 2008.²

The Education Act of 1944 introduced a distinction between primary and secondary schooling and was followed by the introduction of the eleven-plus examination that determined the type of secondary education a child received. One in four passed the eleven-plus and attended grammar schools (or more rarely technical grammar schools), while the remainder attended secondary modern schools and were typically destined to end up in manual jobs. The private sector continued, including the major 'public schools', and these institutions still tutor the political and social elite. In 1965, Crosland in Wilson's Labour Cabinet brought in mixed ability or 'comprehensive state education', which expanded to become the national norm. This system remained largely in place until Thatcher's Education Act of 1988, which emphasised 'school choice' and competition between state schools. In the years since, 'successive governments have sought to reintroduce selection or selective processes under different guises'.³

The evolution of the NHS is covered more fully in other chapters of this volume, so brevity is in order. A political consensus on the 'character' of the NHS held steady through much of the era of welfare state capitalism. Moreover, its 'tripartite' structure – involving divisions between GP, hospital and local authority services – remained largely intact into the 1960s. By the close of that decade, however, the increasing number of people with long-term and disabling conditions in particular provoked calls for a more integrated as well as a more efficient service. The result in 1974 was a bureaucratic reorganisation of the NHS initiated by Heath's Conservative government.

The recession of the 1970s saw the advent of financialised capitalism and a renewed focus on cost containment in health care. In its first year of stability in spending, 1950/1, the NHS had absorbed 4.1 per cent of gross domestic product (GDP); this percentage fell steadily to 3.5 per cent by the mid-1950s; by the mid-1960s, it had regained and passed the level of 1950/1; and by the mid-1970s, it had risen to 5.7 per cent of GDP (see also Chapter 11). In fact, total public expenditure as a percentage of GDP peaked in 1975, accounting for nearly half. The Wilson and Callaghan Labour administrations from 1974 to 1979 felt compelled to take steps to contain public expenditure, including that on the health service. Faced with the prospect of stagflation, Labour retreated from its traditional, socio-democratic stance, most notably with the beginnings of fiscal tightening announced in Healey's 1975 budget. While the 'centre-left technocratic agenda' was not abandoned, impetus was certainly lost.⁴

When Thatcher was elected in 1979, she brought to office a set of convictions fully in tune with the idea that the welfare state was in crisis. She took advantage of Galbraith's (1992) observation that bureaucracy had long been more conspicuous in public than in private institutions.⁵ In 1983, she invited Griffiths (from Sainsbury's supermarket chain) to conduct an enquiry into NHS management structures (see also Chapter 12). The result was the end of consensus management and its replacement by a new hierarchy of managers on fixed-term contracts.

Against a background of a continuing political rhetoric of crises of expenditure and delivery, in 1988 Thatcher announced a comprehensive review of the NHS. A White Paper, *Working for Patients*, followed a year later. The notion of an internal market was the most significant aspect of the NHS and Community Care Act of 1990 that followed. I have argued that 'it sat on a spectrum somewhere between a bureaucratic command and control economy and a private free market'.⁶ Key was the separation of 'purchaser' and 'provider' in what was described as 'managed competition' (see also Chapter 9).

It was Thatcher's successor as Conservative leader, John Major, who introduced the Private Finance Initiative (PFI). This paved the way for the private sector to build, and own,

hospitals and other health care facilities that they then leased back to the NHS, often at exorbitant rents. This was a convenient arrangement for government since PFI building and refurbishment did not appear on government books: they represented an investment of private not public capital. Nevertheless, by the time of Major's departure from office in 1997, expenditure on the NHS had topped 7 per cent of GDP.

Labour prime ministers Blair and Brown were in office up to the end of the period of special relevance to this volume. Both embraced PFIs, despite warnings that many trusts were destined to fall heavily into debt as a consequence. As Allyson Pollock predicted in 2005,⁷ the chickens would one day come home to roost. There was in fact considerable continuity between the Thatcher/Major and Blair/Brown regimes. Blair, too, saw the welfare state as encouraging dependency, adversely affecting self-esteem and undermining ambition and resolve. Labour's 'third way' afforded cover for the sticking with the Thatcher experiment.

In 2000, Blair announced that spending on the NHS would increase by 6.1 per cent annually in real terms over a four-year period. In the same year, 'The NHS Plan' was published. These moves showed a degree of continuity with the Thatcher project rather than a halting of or rowing back from it.

This brief sketch or timeline covers the period of relevance to this discussion, though it will be important to refer to changes to the NHS post-2010 in what follows. It is time now to turn to the nature of the underlying societal shifts that help us to understand and explain these NHS 'reforms' in the half-century from 1960 to 2010.

Parameters of Societal Change

Given the limited space available, it will be expedient here to identify and focus on select themes. The first of these might be termed the 'financialisation of capitalism'. The decade from the mid-1960s to the mid-1970s saw a slow-burning transition from the relatively benign era of post-Second World War welfare state capitalism to a much harsher era of financial capitalism. If it was Thatcher, along with Reagan in the United States, who symbolised and was the principal political champion and beneficiary of this shift, it must be added that in doing so she was surfing much deeper social structures.

It was the American abrogation of Bretton Woods and the rise of the Eurodollar – which freed up money capital from national regulation by central banks – that marked the advent of financial capitalism. The international recession brought banks further and deeper into the global arena. Banks became internationalised and developed closer relations with transnational corporations. References to financialisation grew more common, summing up not only the phenomena of deregulation and internationalisation but also a shift in the distribution of profits from productive to money capital (accompanied by an increase in the external financing of industry). Industrial capital more and more resembled financial capital.

Pivotal for financial capitalism as it developed was a revision of the 'class/command dynamic'.⁸ This refers to the relations between what I have termed the 'capital executive', namely that mix of financiers, rentiers and major shareholders and CEOs of largely transnational corporations that comprise today's dominant capitalist class, and the political elite at the apex of the nation state. The key point here is that those who make up the capital executive in Britain are essentially global operators: they have been described as 'nomads' who no longer belong or identify their interests with their nation of origin. They, like their

capital, can resituate at a rapid and alarming pace. The American historian David Landes once remarked that ‘men (*sic*) of wealth buy men of power’.⁹ What the class/command dynamic asserts, in a nutshell, is that they get more for their money during financial capitalism than they did during welfare state capitalism. This can be interpreted as follows: *capital buys power to make policy*. This is a critical insight for anyone wanting to understand and explain the ramping up of the assault on the principles and practices of the welfare state in general, and the NHS in particular, from Thatcher onwards.

A second theme concerns material and social inequality. Health inequalities are not simply a function of the nature of a health care system, important though this is. Rather, they reflect the distribution of material, social and cultural goods or assets in the population served.¹⁰ I have articulated this elsewhere in terms of ‘asset flows’,¹¹ arguing that strong flows of biological, psychological, social, cultural, spatial, symbolic and, especially, material asset flows are conducive to good health and longevity, while weak flows are associated with poor health and premature death. Moreover, there tend to be strong and weak ‘clusters’ of asset flows. Having said this, compensation can occur across asset flows: there is evidence, for example, that a strong flow of social or cultural assets can compensate for a weak flow of material assets.

The transition to financial capitalism, characterised by its newly distinctive class/command dynamic, has witnessed growing levels of material and social inequalities, with elevated rates of health inequalities following closely in their wake. At the time of writing this chapter, this is being reflected in the specific patterning of the Covid-19 pandemic in the UK and elsewhere.¹² It is not coincidental that attempts to ‘reform’ the NHS post-Thatcher have occurred alongside deepening material, social and health inequalities. The tacit model for these health care reforms, tentative at first but growing in conviction and potency post-2010, is the United States, where commercial interests predominate and yield rich returns. The putative ‘Americanisation’ of the NHS is very much on the agenda (to reiterate, capital buys power to make policy).

To push this point home, it is necessary for a moment to go beyond the timeline of this chapter. The 2010 General Election resulted in a Cameron–Clegg Conservative-led coalition government. Almost instantly this government reneged on a pre-election promise not to initiate any further top-down reorganisations of the NHS. Health Minister Lansley published a White Paper called *Liberating the NHS* a mere sixty days after the election, having consulted widely with private providers beforehand.¹³ This led to the Health and Social Care Act of 2012, a piece of legislation that opened the door for a root-and-branch privatisation of health care in England. There was considerable opposition to the passing of this Act from both inside and outside of the medical profession, but perhaps few realised its likely longer-term ramifications. A decade later this was clearer: what the Act made possible, namely a rapid privatisation of clinical and other services, was underway.¹⁴

In short, social processes of health care ‘reform’ that started around the beginning of the period under consideration here, 1960–2010, have gathered pace since and come to regressive fruition. It will be apparent that this statement has application beyond health care. It is pertinent to physical and mental health alike that ideological assaults on the welfare state have been major contributors to growing material and social inequalities. Like those on the NHS itself, these assaults have accelerated post-2010, culminating in years of political austerity and welfare cuts via devices like Universal Credit. In fact, social security payments in 2020 were proportionally the lowest since the formation of the welfare state back in the time of the Attlee government. Formal social care has been decimated. The advent of the

Covid-19 pandemic in 2020 has exposed these properties of what has been called the 'fractured society'.¹⁵

There emerged cultural shifts alongside structural social change through the years 1960 to 2010. In the arts, humanities and social sciences, these were sometimes characterised as 'postmodern'. One aspect was certainly the foregrounding of individualism, which fed into political and economic ideologies of personal responsibility: remember Thatcher's insistence that 'there is no such thing as society'. Another aspect of the cultural shift has been the 'postmodernisation' or 'relativisation' of culture itself. The French theorist Lyotard put it well when he argued that *grand* narratives had given way to a multitude of *petit* narratives.¹⁶ What he meant was that overarching philosophies or theories of history or progress, or visions or blueprints of the good society, had been seen to fail and consequently been abandoned. Now people had been emancipated: they were free to choose their own identities, projects and futures as discrete individuals. New identity politics had displaced the old politics of distribution associated with welfare statism.

While some commentators and others celebrated this newfound freedom, others labelled it a form of neoconservatism. Habermas, for example, maintained that the announcement of the death of the *grand* narrative was not only philosophically premature but also politically convenient.¹⁷ After all, it followed that no rationally compelling case might now be made for challenging the (conservative) status quo.

The right of the individual to choose – their identities, orientations and practices – has become firmly established in the culture of financial capitalism. It is a major theme running through accounts of 'neoliberal epidemics'.¹⁸ If individuals can be presumed responsible for their behaviour, then they can be held culpable for any medically defined conditions, physical or mental, that can be associated with *lifestyle choices*. If, for example, obesity is causally linked to diabetes and heart disease, and possibly Covid-19, too, then the obese must surely accept some personal responsibility for indulging in 'risk behaviours'. The point here is a political one: it is not that individuals are not responsible for their health but rather that (1) their health and their behaviours are also a function of, often inherited, circumstance and (2) a governmental emphasis on risk behaviours allows for cutbacks in spending and support. Furthermore, given that during the fifty years under consideration here the implicit rationing of health care services has transmuted into explicit rationing, it is only reasonable that 'behavioural conditionality' be factored into decisions about priorities for treatment and care.

This argument has potency beyond health and health care. The political contraction of the welfare state as a whole, together with the spread of 'precarity' in employment via zero-hours contracts and the undermining of work conditions, sick pay and pensions, has been facilitated by a recasting of personal responsibility.¹⁹ Distinguishing between 'stigma', referring to infringements against norms of shame, and 'deviance', denoting infringements against norms of blame, I refer to a *stigma/deviance dynamic* and maintain that 'blame has been heaped upon shame' in the era of neoliberalism. What I mean by this is that citizens are now being held responsible (blamed) for what was previously regarded as non-conformance rather than non-compliance with cultural prescriptions. Thus, people who are disabled are now treated as if this is in some way their fault and similarly with many departures from mental health. If blame can be effectively appended to shame, the thesis suggests, then people are rendered 'abject', permitting governmental sanctions, even punishments, without public protest. The disabled have been among those hit hardest by welfare cuts enabled

by the calculated political ‘weaponising of stigma’. If these processes have only become tangible post-2010, their DNA establishes their origins in Thatcher’s 1980s.

A Welfare and Health Care System Unravelling

The years from 1960 to 2010 reflect major social change. During that period, the exceptionally benign phase of post-Second World War welfare state capitalism came to an end, to be succeeded by a much harsher regime of financial capitalism. While the New Labour years of 1997 to 2010 to some degree saw a stalling of the deindustrialisation, financial deregulation and the programmes of privatisation of the Thatcher/Major years, and a corresponding decrease in the rate of growth of material inequality, this has been no abandonment of neoliberalism.

Financial capitalism has witnessed an accelerating rate of mental as well as physical health problems in line with the fracturing of society. Health inequalities already entrenched by the 1960s have since expanded.²⁰ This was especially true in the 1980s, when Thatcher’s policies of state-enforced neoliberal individualism led to a surge in rates of morbidity and premature mortality among poor segments of the population.

The period 1960–2010 set the scene for what many at the time of writing (2020) see as a severe crisis in welfare and health care. The years of austerity, coupled with a sustained political effort to get citizens to obey the capitalist ‘imperative to work’ as well as to privatise as wide a range of public sector services as possible, have precipitated an ‘Americanisation’ of British society. Cultural cover has been provided for these policies by a populist rhetoric of individualism and ‘freedom of choice’. Scant regard has been paid to the distinction between ‘formal’ and ‘actual’ freedom, in other words between what people are formally free to do (e.g. buy their own house or send their children to fee-paying schools) and what they are actually free to do (i.e. in the absence of the requisite capital and/or a reasonable income).

Conclusion

Starting with a highly abbreviated chronology of the evolution of the welfare state, this chapter has gone on to discuss core structural and cultural mechanisms that have shaped the policy shifts that have occurred, concentrating on the period 1960–2010. The case has been made that policy shifts are often functions of deeper social processes. It is in this context that the class/command and stigma/deviance dynamics have been explored. Discourses, too, typically have ideological components that reflect structural and cultural dynamics. This complicates simple historical chronologies of social institutions like the NHS, as it does debates about improving welfare support and the delivery of good health care. Not infrequently policy-based evidence is substituted for evidence-based policy. Another level of complexity has been added of late, which is largely cultural. This was apparent by 2010 and has been characterised in this chapter as a relativisation of perspectives and modes of thinking. Progeny of this tendency include present analyses of ‘post-truth’ and ‘fake news’, linked to but trespassing beyond social media, each rendering rational judgements based on available evidence harder both to make and to evaluate.

Key Summary Points

- The decade from the mid-1960s to the mid-1970s saw a slow-burning transition from the relatively benign era of post-Second World War welfare state capitalism to a much

harsher era of financial capitalism. Scant regard has been paid to the distinction between 'formal' and 'actual' freedom.

- The recession of the 1970s saw the advent of financialised capitalism and a renewed focus on cost containment in health care. At the same time, new identity politics had displaced the old politics of distribution associated with the welfare state. The political contraction of the welfare state as a whole, together with the spread of 'precarity' in employment via zero-hours contracts and the undermining of work conditions, sick pay and pensions, has been facilitated by a recasting of personal responsibility.
- Strong flows of biological, psychological, social, cultural, spatial, symbolic and, especially, material asset flows are conducive to good health and longevity, while weak flows are associated with poor health and premature death.
- Ideological assaults on the welfare state have been major contributors to growing material and social inequalities. Financial capitalism has witnessed an accelerating rate of mental as well as physical health problems in line with the fracturing of society.
- The period 1960–2010 set the scene for what many at the time of writing (2020) see as a severe crisis in welfare and health care.

Notes

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