
KONSTANTINOS G. DIKEOS

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I hereby declare that this Thesis has been composed by myself.

KONSTANTINOS G. DIKEOS.
ABSTRACT

The Thesis is based on the hypothesis that the policies of the capitalist state and the form of state itself derive from inherent needs and contradictions of capitalist production and class struggles. In order to test this hypothesis the Thesis examines the 'Mode of Health Maintenance' (MHM) a term used to describe the set of policies that contribute to the restoration of health, as a process of maintaining the productive capacity of the workforce in the United Kingdom. Health maintenance is provided through a combination of the state's National Health Service (NHS) and the health care providing provident associations which we call Private Health Insurance Companies (PHIC).

The Thesis questions the importance of the changes in the MHM from 1948 to 1989 period with particular emphasis on the 1979-89 period. It assesses the potential undermining of the functional-reproductive contribution of the National Health Service or their contribution to the construction of the 'post-fordist' society and the relationship between both the changes and their analysis can give to our theoretical premises. In the pursuit of an answer to the question, the Thesis relates the development of the NHS to the levels of morbidity and absence from the workplace due to health reasons, and to the development and expansion of the PHIC. Additionally the Thesis examines the relation between the development of the PHIC and the so called transition to a 'post-fordist' society.

As a methodological approach, the Thesis is an analysis in line with Miliband's study of the relation between theoretical analysis and applied research, using the Mode of Health Maintenance as a case study.

The Thesis consists of three Parts: the First sets the historical framework, the theoretical hypothesis - making a critique of current theories- and the questions arising. The Second analyses the NHS the PHIC and the levels of morbidity in British society and relates NHS funding and performance to the development of the private health care option and to the changes of morbidity levels. Finally, the Third brings all arguments together and concludes on the form of state, and state policies returning to our initial contention that the state and the state policies should be seen as the outcome of needs and contradictions of capitalist production and class struggles, and emphasising the necessity for empirical research in order to reevaluate our theoretical hypothesis.

The Thesis uses a variety of sources. Most of them are primary data collected from HMSO publications concerning state expenditure for health, morbidity levels, absence from the workplace, and non governmental sources of data for data concerning the development of the private health care providers. The secondary and theoretical sources of the thesis are commentaries on British politics and publications on state theory and Marxist political economy and state theory.
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Last but not least, a great ‘thank you’ should go to the staff and students of the Politics Department and to the people of Edinburgh, who with their friendly manner made my stay over these five years more than pleasant. Had it not been for my parents, this Thesis should had been surely dedicated to them.

KONSTANTINOS (COSTAS) G. DIKEOS
TO MY PARENTS
INTRODUCTION.

This Thesis will examine the set of policies that the contemporary British state has adopted and implemented in order to maintain the workforce healthy enough, or to restore the health of the workforce quickly, as to achieve low rates of absenteeism due to health reasons from the workplace. The past twelve years have seen a great deal of changes in state policy (or at least a great deal of rhetoric about change of policy) in Britain. There have been lengthy discussions about abandoning the policies of Keynesianism (Keynesian demand management of the economy, and Keynesian Welfare State) and adopting monetarism. These debates include arguments on both sides, viz. that the government has followed a wrong course by implementing such policies ('left' academic literature), and that these policies are not adequately implemented (literature of the Institute of Economic Affairs and the other New Right 'think tanks'). The rhetorical motto of the Thatcher governments was about "Rolling back the state" and fighting against the 'establishment' (the 'establishment' being the trade unions, social democratic policies etc.). It was a confrontation between the 'radicalism' of the New Right ideology of Friedman, Hayek, Buchanan et al. with the consensus ideology of the periods of Keynesianism and social democracy which has been referred to as 'Butskellism'.

The post 1979 period was named 'Thatcherism' after the surname of the Prime Minister. There have been long discussions on Thatcherism, a subject now covering some 300 titles (including titles related to 'contemporary British politics from 1979-today') and as a consequence, the term though widely used, does not have a single meaning. One of the main debates about Thatcherism is whether it represents a change (or indeed a radical change) in British politics or just a continuation of events that started in the early seventies under Mr. Edward Heath. The other important debate about Thatcherism is (was in mid eighties) the one between M. Jacques and S. Hall on the one side (claiming that Thatcherism represented a form of 'new hegemonic project' and 'Authoritarian populism') and Jessop, Ling, Bromley and Bonnet on the other (claiming that the 'hegemonic project of Hall and Jacques was not well defined and that Thatcherism should be analysed by a 'Two Nations Approach').

1 “An amalgam of R. A. Butler, the Conservative Chancellor of the Exchequer 1951-5, and Hugh Gaitskell, his Labour predecessor and shadow” (Dennis Kavanagh, 1987, p. 4).
2 The first such term to be coined after the name of a premier.
3 For more information on this debate see Part I, Chapter 2.
However, these discussions about the form of Thatcherism did not improve state theory and our understanding of the capitalist state. For one key commentator on Thatcherism (Bob Jessop) the two issues (state theory and analysis of Thatcherism) remain two different spheres of interest: in his book ‘The Capitalist State’ (1982) he does not mention Thatcherism when discussing state theory. Theories about the capitalist state were rather neglected, while the focus of interest was on the analysis of the policies of the Thatcher governments. Such an analysis of Thatcherism offers comments on functions of the state and not on the state itself. (Jessop, Hall in their argument/debate do not comment on development of the state, but on policies of the Thatcher governments and attitudes of the state). Such an approach appears (in a lesser extent) in Gamble 1989 as well (‘Free Economy and Strong State’).

Thus, state debate seemed stagnated. It could be argued that there has not been any important contribution to state theory after the Capital Logic School (German Derivation, and French Regulation) and Offe’s analysis about the inherent ‘Contradictions of the Welfare State’; and (more recently) the critique of these theories (more the Capital Logic than Offe) by Bonefeld, Clarke and Holloway. However Bonefeld, Clarke and Holloway criticise mainly Jessop’s work and the political implications of Jessop’s work in particular (Holloway). In general the theoretical approach to the state has been neglected during the recent years, or this approach has been at a very ‘abstract’ level not discussing current political developments (Jessop 1982, Bonefeld 1987/91).

What is lacking from contemporary political analysis and state theory is a relation between the development of certain policies and state theory, in other words a new attempt to derive the formation of the state from the formation of (public) policy, and political events and developments. From our point of view this can be achieved by the adoption of a case study on a wide section of state policies, that will assist in the (re)formation of a theoretical understanding of the state, viz. to a (re)evaluation of our state theory.

As a case study area we have chosen the way the British state has adopted in order to keep its workforce healthy and productive. We call this ‘way’ or ‘set of policies’ “Mode of Health Maintenance” (or by its abbreviation MHM). By MHM we mean the combination of the National Health Service (or by its abbreviation NHS) and the health care providing

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4 For a more detailed analysis and further references see Part I, Chapter 1.

5 See Part I, Chapter 1 and Chapter 3 and Part III, Chapter 1.

6 Or to put it better: “to restore the health of the workforce ex post festum” since we will not examine sanitation and immunisation policies, or policies of preventive health eg anti-smoking policies.
provident associations (BUPA, PPP and WPA)7 which we call Private Health Insurance Companies (or by the abbreviation PHIC)8. Recently there has been widespread controversy about the future of the NHS, due to the new Law which gives the NHS hospitals the opportunity to achieve ‘trust status’ and ‘opt out’ of the control of the Area Health Board and creates ‘internal markets’ for the NHS hospitals which will ‘compete’ for ‘customers’. There have been allegations by the opposition that there is a ‘creeping privatisation’ of the NHS ‘in the process’, and counter allegations by the government that the opposition is offering ‘red herrings’ in order to avoid serious discussions about the reorganisation of the service. These discussions and debates, though, direct interest away from some other ‘old’ changes, which are as important, and their results can be much more easily measured as they are in the past (and recorded in data sources), and not in some controversial speculation(s) about the future.

We are particularly interested in the changes undertaken in the NHS and in the MHM in general between 1979 and 1/4/89, when the new Law was enacted. By these ‘changes’ we refer to the Acts of 1980 (Chapter 53 of the Book of Statutes) which introduced a ‘roof expenditure’ and ‘private raising of money for the hospitals’ and reintroduced the private pay-beds in the NHS (abolished in 1976), and at the organisation level centralised the NHS; the 1984 Act (Chapter 48 in the Book of Statutes) which had the same organisational aims; and the 1988 Act (Chapter 49 in the Book of Statutes) which introduced payment for eye tests9. Additionally (and predominantly), we are referring to the development of public expenditure for the NHS (again there has been a controversy about the NHS funding with the opposition alleging that the NHS is starved of resources and the government answering that ‘we are spending on health much more than ever before’) and to the changes in the number of NHS staff (which has produced once more the same controversy)10.

The obvious questions that arise from such an observation are: How important are these changes? What feedback can these changes give to our theoretical approach of the state? Are these changes going to undermine the reproductive functions of the KWS as described

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7 British United Provident Association; Private Patients Plan; Western Provident Association. There are some more providers of private health care. These are the NHS hospitals offering ‘private “pay” beds’ when paid directly by the user and not through a PHIC, and the various commercial insurance companies (eg Norwich Union, Sun Alliance etc.) which have recently developed health departments. We concentrate on the three main PHIC because between them they control about 93% of the market. See the relevant Chapter 2 of Part II for more details.

8 These organisations are not ‘companies’ in the legal concept of the term, as they do not have shareholders and they do not seek profits in the accountancy-legal concept of the term. However, their market behaviour, pursuits and policies resemble very much those of the commercial insurance companies, thus the choice of terminology. For more details on the justification of the term see the relevant Chapter 2, of Part II.

9 For a better approach to these Acts see the relevant sections of Chapter 1, of Part II.

10 See, Part II, Chapter 2, for a detailed analysis.
by the Capital Logic School? Or are they assisting in the formation of a new way of reproduction to match with a new norm of capitalist production the so called transition from ‘fordism’ to ‘post-fordism’? The government is trying to control expenditure (and even reduce it) in order to reduce taxation as well in an aim to assist economic growth. Thus, our questions, seen in conjunction with our theoretical framework can be put in one phrase as: “do the cuts and changes in the Mode of Health Maintenance in the United Kingdom between 1979 and 1989 illustrate the rational pursuit of the creation of a new (‘post-fordist’) workforce, or is this an example of the state acting against the long term interests of capital”?

In the pursuit of an answer to the question the Thesis examines the development of the NHS and the PHIC from 1948 to 1989 with particular focus on the ‘Thatcher’ period, and relates the development of the NHS to the levels of morbidity and absence from the workplace due to health reasons, and to the development-expansion of the PHIC. Additionally the Thesis attempts to examine the relation between the development of the PHIC and the so called transition to a ‘post-fordism’ society.

We have chosen this subject because we think it is controversial, interesting and can provide us with an important case study related to current policies and politics. As we suggest earlier in this introduction, current political commentaries have neglected the relation between political analysis and the (re)formation of state theory. This Thesis aims to reintroduce an examination of the relation between theoretical approach and empirical evidence (as with Miliband, in his debate with Poulanzas) trying to track down data that is easy to examine.

The objectives of the Thesis are to (re)evaluate the existing state theory, in other words the Capital Logic School (French Regulation and German Derivation and their British followers eg Gough), in relation to Offe’s analysis of the contradictions in the relation between the welfare state and the capitalist mode of production and (on the other hand) the critique of the Capital Logic School (and to Jessop’s structuralism) by Bonefeld Clarke and Holloway, and last but not least, to examine the validity of the theories about a transition to ‘post fordism’ in a methodological way which we would like to call ‘post-Miliband-ian’.

The key idea behind this approach is to apply state theory to current political developments and (re)set our theoretical conceptions.

The sources we have used in the pursuit of answering this question can be classified as primary, secondary/commentaries and theoretical. By primary sources we mean the sources of crude data, such as the editions of the Central Statistics Office, and other government

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11 For an analysis of the terms ‘Fordism and ‘Post-Fordism’ see, Part I, Chapter 1, section 1 ‘Definitions’.

12 The sources are discussed with detail in the beginning of each Chapter as well.
and Crown publications such as the ‘Population Trends’, the ‘General Household Survey’, the ‘British Social Attitudes Survey’, the ‘Employment Gazette’\textsuperscript{13} and other similar publications (broadly speaking they are the publications of Her Majesty’s Stationery Office), and of course the Book of Statutes, the White Papers and the (ad hoc) Commission Reports themselves; while for the Private Health Insurance Companies additional sources were the companies themselves through private correspondence (including one interview) and the data of the Fitzhume Directory of Private Health Care. The secondary/commentary sources are books and articles commenting either on particular cases of the primary sources or on political developments. By theoretical, sources we mean the approaches that construct our theoretical framework viz. the work on state theory (Capital Logic etc.) which we will attempt to apply to the contemporary changes.

The Thesis consists of three Parts. Each Part opens with a short introduction and is then divided into a number of Chapters (Parts I and II have three Chapters each, Part III has two). Each Chapter is divided into a number of sections and each section into subsections, and where necessary the subsections are divided into ‘paragraphs’\textsuperscript{14}. Part I sets the framework and questions of the Thesis, Part II attempts to answer the questions by pursuing original research on the MHM, and Part III approaches the conclusions of the Thesis.

The first Chapter of Part I, gives some definitions of terms to be widely used in the rest of the Thesis and then discusses the theoretical approaches in the form of German Derivation, French Regulation, Contradictions and the critique by Bonefeld, Clarke and Holloway, and then makes some theoretical conclusions about the problems of reproduction of the productive capacity of the workforce, the state, and the relation between them, raising a critique of the existing approaches. Chapter 2 makes a general approach to British post war politics with particular reference to the construction and reconstruction of the Keynesian policies and the KWS, and other issues of the Thatcher governments, and discusses the main approaches to the policies of Thatcherism viz. the ‘Authoritarian Populism’ and the ‘Two Nations’ Schools. Chapter 3 makes these conclusions clearer and raises and discusses the questions arising from such a theoretical approach to politics when confronted by the developments in policies and politics that have occurred in the post 1979 period, and discusses an alternative method of approach, which we think more appropriate.

In the first Chapter of Part II, we examine the National Health Service. The legislation relating to it, its funding, its level of equipment and personnel, and the level of services it

\textsuperscript{13} The Employment Gazette can be classified in the secondary/comments data as well. This depends on the contents and context of the information used in each particular case.

\textsuperscript{14} We use the term ‘paragraph’ for the sake of division. These ‘paragraphs’ might be longer than a page and consist of more than one block units of text which are paragraphs in the strict ‘grammar’ sense of the term.
offers e.g. of the length of the waiting lists and the duration of in-hospital treatment. Then, we turn (in section 2 of that Chapter) to the actual results of the NHS as an MHM and examine the levels of morbidity and absence from the workplace due to health reasons, and the problems this absence inflicts on capitalist production. The Chapter closes with some first conclusions on the issue (section 3). The second Chapter attempts a similar approach to the PHIC, but it does not relate the results to morbidity but to the argument about a transition to ‘post-fordism’. Lastly Chapter 3, concludes on the whole Part II, bringing together the various arguments and data that have been examined earlier, with emphasis on the relation between NHS funding and morbidity, and the NHS and the PHIC.

Part III has only one main Chapter which relates the theoretical framework of Part I to the empirical findings of Part II and the conclusions drawn from these findings trying to offer some new suggestions about an understanding of politics. The second Chapter of Part II recapitulates the main findings of the thesis and examines the limits of the approach raising some self-critical points.
PART I

"THEORETICAL FRAMEWORK, HYPOTHESIS AND HISTORICAL BACKGROUND."
"INTRODUCTION."

This Part of the Thesis will set the political-historical and theoretical frameworks within which the research on the British Mode of Health Maintenance will be conducted (in Part II). The approach to the political-historical framework follows the one to the theoretical premises because we believe that it better to set the basis and foundation of our theoretical understanding of the state in advance.

The theoretical framework discusses the main approaches to the state and the welfare state and to the forms of state and norms of capitalist production that have developed after the war, and in contemporary times in particular. The theoretical framework gives an understanding of the state and of the welfare state and the MHM in particular provides the setting for the theoretical hypothesis which is scrutinised in Part II. It examines the relation between capitalist economy and norms of production on the one hand and forms of state policies on the other. Last but not least, it examines the issue of the applicability and necessity of empirical research, in order to evaluate Marxist theoretical presuppositions, inclining to a ‘Miliband-ian’ approach to political research.

The political and historical framework will discuss the changes in British political history and politics after the Second World War (‘war’ hereafter), with particular reference to the construction of the welfare state after the war and its reconstruction after 1979. It will discuss aspects of the British state and of the ‘Thatcherite’ state in particular and it will assist as a general introduction to British political developments and discussions on British politics.

Thus, the comparison of the political-historical framework with the political-theoretical one gives rise to some questions about the applicability of theories developed in the mid-nineteen seventies (and their critiques later on) to contemporary politics when we consider the changes that have occurred after the formation of those theories. Consequently, Part I is divided into three chapters. Chapter one discusses the theoretical framework. It introduces us to the ‘Capital Logic’ school according to which the state undertakes certain functions and intervenes in the economy and production because it acts to the benefit of capital and to the contradictions this intervention may produce on the one hand; and the critique of these theories as ‘functionalist’ on the other as the result of ignoring the issue of class struggle. In the concluding sections of Chapter 1 we give our own theoretical approach to the state and the welfare state in particular.

Chapter two discusses the changes in British politics since 1945 (with some reference to the era before) and after 1979 in more detail, and gives a summary of the main approaches to the Thatcherite state. Chapter three, approaches the questions to be examined in the rest.
of the Thesis, the data sources and the ways to analyse this data mentioning its limits. The sources used are primary, secondary and theoretical. Chapter 1, the state theory chapter, has mainly theoretical sources. These are textbooks and essays about state theory and discussions of the state phenomenon and its manifestations. Chapter 2, the 'background information chapter', uses both primary and secondary sources, the primary being Government Publications on state revenue and expenditure in the discussion of policy change in taxation and allocation of resources, and the secondary being commentaries on British politics and political history, that will assist us in the formation of an understanding of the developments and of the Thatcherite state as such. Chapter 3 has mainly primary sources (Government statistical publications) in order to discuss their (in some cases self-mentioned) limits.
CHAPTER 1.

"THE WELFARE STATE AS THE OUTCOME OF THE PROCESS OF POLICY MAKING."

INTRODUCTION.
This chapter will examine the theoretical approach to the reasons for the creation, expansion and sustaining of policies of the Keynesian welfare state in post war Britain and for the challenge of these policies by the Thatcher governments. Consequently, it will try to develop a theoretical understanding of the policies of the state and of the state itself, and it will spell out the reasons for the limits to the transformation of the welfare state. We will do so by analysing our theoretical terms and hypothesis and raising the issues which we will analyse in the next Part of the Thesis.

The Chapter is going to be divided into three main Sections, with a short fourth one recapitulating the main arguments and conclusions and raising questions related to them and to the developments in contemporary British politics.

Section One discusses the definitions of terms to be used throughout the thesis. Section Two will review the recent Marxist literature about policy making and state theory; Section Three focuses on our particular theoretical approach to politics including our critique of the existing literature and hints our hypothesis and questions, which are discussed initially in Section Four (and in Chapter 3 in more detail).
SECTION 1:  
"Definitions"

There are a number of terms that are going to be used widely in this Thesis, and need definition. While the next chapter will examine the creation of the (Keynesian) Welfare State and of Social Policy and will try to define them in a descriptive way, this one will examine the policies of the welfare state by exploring their impact on the process of reproduction of capitalism and of the ‘fordist’ and ‘post-fordist’ forms of capitalist in particular; we will refer to the notion of ‘public utility’ which is always implicit in the use of the term welfare state. Additionally, the KWS is going to be seen as the outcome of ‘class struggles’ and ‘class alliances’. In the next few pages we will examine terms ‘class struggles and alliances’, ‘fordism’, ‘post-fordism’, ‘public utility’ and ‘reproduction’, so to assist our approach to the changes of the contemporary KWS and their significance for ‘reproduction’ and the capitalist state.

Class struggle

By this term authors usually mean the resistance of the working class to the domination by the bourgeois class. However, this is only a case and manifestation (maybe the clearest one) of class struggle. Class struggle at a much more general and abstract level is the fight about the form of accumulation and production and the form and norm of production and reproduction, and the clash over the distribution of product.

Additionally, class struggle is not one sided. It is not only the proletariat struggling against the bourgeoisie. It is the bourgeoisie that struggles against the proletariat too, as the bourgeoisie try to impose their will.

It should be noted that class struggle does not always take a ‘civil war’ or ‘military’ or ‘revolutionary’ form. On the contrary, these cases are extreme examples of class struggle, when the conflicting interests can not be controlled by or contained in the political and institutional framework. Then the struggle takes the form of a revolution against the

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1 These are the two ‘main’ classes. From our point of view class position should be assumed from the relation of the individual to the means of production, and his/her position in the relations of production (manifested by the wage relation) and his/her self class consciousness. Issues that relate class position to the ability to consume belong to a behaviourist and not a Marxist approach to politics, and though sometimes useful are irrelevant to a Marxist analysis and to the term class, the term social stratum being more appropriate. Last but not least, the recent (post 1979) case of ‘traditional working class’ people owning shares (often of the very companies they work for) makes no difference at all to their class position or whatever, since they do not control their work and the product of their labour, and their real relation to the company is the wage relation. Pet share ownership is a form of personal investment similar to a bank account and does not make the member of the working class a bourgeois. See the treatment of the relation class and stratum in Chapter 3 ‘Questions, Sources and Data’.

2 See eg. Marx Capital p. 299 on the struggle for the normal working day.
framework, apart from the day to day the confrontation against the dominant class. But usually class struggle has a much more subtle form. The various policies (either state polices, or industrial and trade union ones) are manifestations and arenas of class struggle. Ideology and trade unions can be used as particular examples of manifestations and arenas of class struggle, without class struggle taking a 'revolutionary' form. Ideology is an element, manifestation and factor of class struggle as it tries to integrate 'other' classes'. Work contracts and strikes are parts of class struggles. The formation/construction of trade unions and the (at first) unwillingness of the bourgeois state to accept them (and of the bourgeois to 'recognise' them), and to legalise them, and later the attempts to control them through legislation, are manifestations and arenas of, and should be included in the concept and notion of class struggle. From our point of view, class struggle has to be approached and understood in a broad sense, otherwise it will not be understood adequately, and subsequently, our understanding of politics will be inadequate. Class struggle should not be seen apart from class alliances, since class alliances are an element of class struggle.

The petit bourgeoisie and the middle classes intervene mainly in the fight/struggle over the distribution of the product and control of petit-property (see Marx's analysis about the 'Defeat in June 1848'). And the attempts of the bourgeois to impose their will, over the distribution of the product in such a way that is not favourable to these classes, by the use of a 'unifying' ideology.

This is how class alliances can be formed. The main conflict/struggle is between/among the two 'basic' classes the bourgeoisie and the proletariat. In the process of class struggle the 'other classes' feel their position/possessions threatened by one or another class, depending on strength, potential and objectives of each class, and on the possible outcome. Thus, they ally themselves with whichever class that will best serve their interests (or at least will least threaten their interests). Of course, any of the two main classes might modify objectives (or just claim to have modified objectives) in order to win alliance of the 'other' classes'.

Politics is the making of economic and social policy. The making of these policies is 'by

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3 This is the function of the dominant ideology, which is the ideology of the dominant class. The ideology of the subordinated class is critical to the system. See relevant footnotes in next Chapter 2.
4 For recent changes in Trade Union legislation in Britain, see Chapter 2.
5 K. Marx, 'Class Struggles in France'. See Part III Chapter 1 'Conclusions' as well.
6 This case in Gramsci and especially in post-Gramscian political theory i is referred to as hegemony (or in some cases as hegemonic project)
7 For an approach to recent changes in British class struggles and class alliances see...
definition' a field of conflict. This conflict is in the form of the clashes between different classes and their alliances viz. class struggle and conflicts that take place within one class - mainly the bourgeois class- which are sometimes referred to as ‘interbourgeois* conflicts. The very reason of these ‘interbourgeois’ conflicts is the different forms, functions and appearances of capital, and the different interests invested on each of these forms, functions and appearances9. The clearest manifestation of these ‘interbourgeois’ conflicts in Britain is the division of interests between ‘Industry’ and the ‘City’ over long term monetary strategy of the government, with focusing point the interest rates policies.

Fordism.
The norm of production of the post war boom has been ‘christianed’ ‘Fordism’. The term initially appears in the ‘Prison Notebooks’ of Antonio Gramsci in reference to (the United States of) America and the pre war reconstruction of the car industry in Northern Italy and Europe in general. It derives from the organisation of work in the Ford Highland Park Plant in Detroit, where it was introduced in 191310 for the mass production of the Model T and (later) of the (cheaper) Model Ts car.
The norm of production introduced by Ford was fully incorporated in European plants in the mid forties (following the second world war)11. The work is organised along an assembly line requiring semi-skilled human labour.

“This pattern.....was characterised by the close articulation of mass consumption with the mass production of standardised commodities by semi-skilled workforce in large factories.” (Holloway 1987, p.54),

while Bonefeld adds the issue of intensive accumulation (1987/1991). For J. Hirsch (in Kapitalistate 11/12, 1983), ‘Fordism’ which is based on ‘Taylorised’ production, but as a system goes beyond it, “is a historically distinct capitalist social formation with its own economic, political and ideological characteristics”. The whole society is constructed

8 Or -in German where the term originates from ‘interburgluche’ conflicts. See Ingham 1989 and A. XapaAiap.7T| about interbourgeois conflicts in post civil war Greece. XapaA.ap.7T| being influenced by German writers uses the term throughout his work.

9 This question will be approached in great detail in Part III ‘Conclusions’, while a brief approach to the policies themselves exists in the next Chapter 2. See the work of S. Clarke who believes that it is wrong to examine capitalism in a ‘fractionalist’ way (Clarke 1978, 1987), however, the leading article of the Financial Times of 26/5/1990 gives ground to ‘fractionalist’ analyses.

10 Ford Motor Company was launched in 1903. The ‘five dollar day’ was introduced in 1914. Model T and Model Ts were being produced up to 1927 at an aggregate number of 15,007,003 automobiles (Beynon, 1984, pp. 31-39).

11 This is why we claim that the creation of the ‘New Jerusalem’ or of the ‘new home’ in the post war period does not coincide with the victory of the allied forces in El Alamein, but that there were other reasons as well; see next Chapter 2, about the construction of the KWS in post war Britain.
around the assembly line, and seems prosperous due to the relatively high wages paid. However, Gramsci had questioned:

"meanwhile, what is meant by 'high wages'? Are the wages paid by Ford high only in relation to the average American wage? Or are they high as a price for the labouring power expended by Ford's employees in production and with those methods of work?" (Gramsci 1986, p.311).

For Gramsci there is not an adequate answer to this question, while H. Ford I himself (as quoted by Marquis 1923, our quotation from Beynon, 1986, p. 38) believed that

"a man who can pay a living wage and refuses to do so is simply storing up trouble for himself and for others. By underpaying men, we are bringing on a generation of children undernourished and underdeveloped morally as well as physically; we are breeding a generation of working men weak in body and in mind, and for this reason bound to prove inefficient when they come to take their places in industry."

Thus, we can refer back to J. Hirsch (oc.) who argues that

"Fordism thus denotes a secular 'long wave' of expanded capitalist accumulation by which the reproduction of labour becomes a central sphere of the valorisation of capital." (our emphasis).

So, 'fordism' is a norm of production, which constructed a whole form of society (referred to as 'fordist society'), which is based on mass production and mass consumption of durable commodities, and requires (even by its inventor's words) adequate labour power for its perpetuation, this being a 'sine qua non' investment for the capitalists. The question that arises now on is whether this investment can take just an wage form, or it has to be paid for through some other way, due to the fordist formation of society itself, and the aspirations of the working class as well. In the course of this thesis the question is going to be expressed as 'who is to pay for reproduction'? But at first we will turn to the issue of 'post-fordism' which is supposed to be the period which follows 'fordism' and which according to some scholars the current period should be considered as 'post-fordist'12

Post Fordism.
The term first appears in English in M. Aglietta's 'A Theory of Capitalist Regulation'

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12 While, as we will claim later in this Thesis, we are much more in favour of calling this period a 'transitional period towards a (potentially) post fordist society and state'.
(1979)\textsuperscript{13} and is used by various Marxist scholars thereafter. As Bonefeld suggests while ‘fordism’ is an era of an economy of scale, ‘post-fordism’ is an era of economy of scope (see Bonefeld, in Bonefeld and Holloway forthcoming 1991, ms p. 114, and in Capital and class 33 p. 114). Production in ‘post fordism’\textsuperscript{14} is not organised around the assembly line\textsuperscript{15} (as in fordism), but is highly computerised and automated so that the worker is required (and able) to undertake various different tasks during his/her shift. In the contemporary political literature, this requirement (and ability) is called ‘flexibility’. Flexibility can be either numerical or functional. In numerical flexibility we have two groups of workers (a) the ‘core’ workers who are skilled and central to the companies’ activities and (b) the ‘peripheral’ workers who are less skilled and less important for the company. In ‘functional’ flexibility workers are moved from job to job according to their skill, match and level\textsuperscript{16}. While a slightly different view of flexibility is given by

“Stephen Conneck, industrial relations manager with Philips Electronics, (who) suggests that there are three forms of such craft flexibility: core skills where the basic skill is retained, but the employee has an appreciation of skills required in other jobs; dual skills, where proficiency in another discipline is added to the core skill; and multi skilling where the employee uses a wide ranging variety of skills” (Bassett 1986 p. 97).

Additionally, flexibility has expanded the duties of the employee from the operation of the equipment to its maintenance and attempts to transform the competition from the concept of a clash between employers and employees, to the concept of market competition between different companies (ibid. 99)\textsuperscript{17}.\textsuperscript{18} Or, as Aglietta 1979 puts it, “The workers are no longer subjected to a constraint of personal obedience, but rather to the collective constraint of the production process” (p. 128). According to Holloway, who takes a critical view of the developments in his ‘Red Rose of Nissan’ emphasising on the in-factory capital-labour relation

\textsuperscript{13} To be more precise the term used by Aglietta in Neo-Fordism and not Post-Fordism, while the term itself was at first coined in French by Christian Palloix: in La Pensee, no. 185, February 1976, see Aglietta oc, p. 122 footnote 4. On the other hand, Michael De Vroey 1984, predicts a new form of accumulation (due to the collapse of the -then- current one) but he does not name it post (or neo) fordism.

\textsuperscript{14} Of course the analysis here is (to put in in Weberian terms) an approach to the ideal type of post fordism; variations however may exist.

\textsuperscript{15} Requiring semi-skilled manual labour.

\textsuperscript{16} Philip Bassett, ‘Strike Free’ page, 95. In this case Bassett quotes from J. Atkinson.

\textsuperscript{17} For a different account of flexibility see Piore and Sabel 1984, pp. 265 ff. Piore and Sabel are mainly interested in the overall structure of industry and the relation between different branches of companies and different companies (and their location within geographical regions).

\textsuperscript{18} This is of particular importance for the issue of class struggles and class alliances, see later on in this chapter and Part III.
“Flexibility means essentially the removal of barriers to management’s right to tell the workers what to do, where to do it and at what speed. The workers should no longer insist on job demarcations: they must be ‘flexible’ enough to move from one job to another” (ms page 12).

Thus, production is organised in two levels. The ‘core’ workers who are specialised and work for the (main) company itself, and the ‘peripheral’ workers who usually work for suppliers or subcontractors. The core workers enjoy good working conditions and high salaries (not living wages any more!), industrial security, no visible distinctions from their foremen, supervisors and managers, while on the other hand they sometimes offer no strike agreements. In contrast to this the ‘peripheral’ workers do not have high wages, safety in the workplace is not as good and job security low, as they work on short term contracts. They become more easily unemployed and in general they are less important and more ‘expendable’ than the ‘core’ workers.

Though one side of the issue, and a possible answer to the question about the change in the structure of industry towards post-fordism is this of raising productivity via reorganisation of work, Holloway in the ‘Red Rose’ suggests that this is a management viewpoint and that in Marxist terms

“Capitalist crisis is never anything other than that: the breakdown of a relatively stable pattern of class domination”. It appears as an economic crisis, expressed in a fall in the rate of profit, but its core is the failure of an established pattern of domination. From the point of view of capital, the crisis can be resolved only through the establishment of new patterns of domination. This does not mean that capital has got new patterns ready-made to impose on the working class. For capital, the crisis can be resolved only through struggle, through the restoration of authority...” (ms. p. 6).

The article goes on to describe the clashes between capital and labour in the mid and late seventies focusing on strikes in British Leyland and (for early eighties) on the coal miners strike; and ends up with the ‘solution’ of the crisis in the new Nissan factory at Sunderland and the agreements and factory policies there.

These policies are usually matched with single union agreement (or even with policies of no

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19 A. Pollard in her “Dismantling Flexibility” (Capital and Class 34) relates flexibility to gender and refers to the changes and problems in female employment.

20 For a more detailed analysis see as well Bonefeld oc, Holloway ‘The Red Rose of Nissan’ in Capital and Class 32, and ‘A Note on Fordism and Neo Fordism’ in Common Sense 1. The article (‘Red Rose..’) makes a comparison and argues that there is important similarity and compatibility between the industrial relation policies pursued in the car (and coal) industry and the policies of the state as the objective of both are the struggle by capital to impose its right to manage. A critical approach to the ‘Red Rose’ examining the empirical foundation and derivation of conclusions is offered in Chapter 1 of Part III, ‘Conclusions’.

21 This patterns for Holloway being Fordism and Keynesianism for the post war (and especially 1960s to mid seventies) period in Britain.

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union recognition) or even with attempts to turn the ‘flexible’ workers against the Trade Unions. This, at least in Britain can be explained as a bourgeois counter attack on the working class and the organised labour as

“...failings which emerged clearly in international comparison were bad and slow workmanship; extremely poor maintenance work; and numerous labour disputes and strikes. In those years (1960s to 70s), the motor industry took over the lead from the miners in strike proneness, particularly harmful in an assembly industry where holdings in one sector quickly affected the output of others. The number of strikes was extraordinary high also by international standards” (Pollard, S. 1983, p. 291).

As Dr. James MacFarlane (Director General of the Engineering Employers Federation, quoted by Bassett 1986, p. 88) mentions, adopting workplace flexibility enables the employer to select a moderate and progressive union and to achieve ‘no-strike’ agreements. Additionally, some employers are not willing to recognise unions in the workplace, and a number of employees are not interested in being unionised.

In general Post (or Neo) Fordism can be understood as a new system of industrial relations and a new mode of production and accumulation and as Aglietta 1979 (p. 385) sets it “Capitalism can escape from its contemporary

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22 See eg. Bassett 1986, pp 100-101 about strike free agreements of the EETPU, which are matched with agreements for the provision of private health insurance (something of particular interest for this Thesis -to be addressed in the next Part), or the EETPU-Toshiba agreement (single union-six unions gone-, strike free, new working conditions, employee involvement) (ibid. 126) and p. 135 for the EETPU-Hitachi agreement, which has the particular interest in having about 25% of the personnel redundant prior to the signing of the agreement. See Holloway and Palaez in Bonefeld, Holloway forthcoming 1991 (or -initial publication-in Science as Culture no 8 Summer 1990) about the attempts of capital to regain control over production by the imposition of ‘post-fordist’ techniques.

23 As Basset mentions in 1984 (in Scotland) 56% of US owned industries recognised trade unions (though this number fell sharply in high technology companies), while 92% of those who recognised Unions considered them “to have a favourable or neutral impact on plant operations” (p. 24). Most of the personnel (average age 17 and a half) never thought of joining a union for some chance of protection, against dismissal “but even when it had happened they still had no intention of doing so” (ibid). In 1985 58.7% of workers in hightech industry were not unionised and 89% of companies did not have any strikes (p. 29). For one more account of post fordism (with Scotland as a case study) see Foster and Woolfson 1989, who mention the ‘Japanisation’ an redundancies in the Scottish industries.

24 See Bonefeld oc p. 117 as well. Bonefeld concentrates on the transformation of the Unions towards the representation of the core workers only, and as far as function is concerned towards services instead of articulation and representation of demands ones.
(1979) organic crisis only by generating a new cohesion a Neo Fordism\textsuperscript{25,26}. In both Fordist and Post Fordist regimes wages are (relatively) high (in post fordism for its ‘core’ personnel only). Taking as an hypothesis that reproduction is going to be paid for through an increase in the wages, we could refer ... to the anxiety of Lord W. Beveridge about the use of the benefits provided. That the increased income should not go to unnecessary luxuries etc., but to items contributing to the welfare and happiness of the people. I think that we have to make a sharp distinction though. The issue for Lord Beveridge was more moral/ideological, while for us it is more related to the problem of reproduction\textsuperscript{27}. Taking the example to the extreme, we could suggest that if the increased income (from the relatively higher fordist wages) went to the use of drugs and the abuse of alcohol this could have, as a result, problems both in production and in reproduction. In this sense the money given in wage form is an investment (let us remember here the citation of Henry Ford I) and should work as such! In other words, it should be secure for Mr. Moneybags that increased spending now can lead to increased or at least standard and without stops and goes earning in the years to come. The central question is who and under what conditions will take action so this prerequisite for the perpetuation of capitalism will be achieved\textsuperscript{28}.

Public Utility as a term is related to the capitalist formation of economy. As O’Connor (1973, p. 71) mentions before the development of capitalism, public property was property of the then ruling classes, a very clear case in feudal societies. For O’Connor it was the development of commercial and industrial capitalism that separated public property from the

\textsuperscript{25}For Clarke (in Bonefeld, Holloway forthcoming 1991, ms. 130, footnote 4) the term Neo Fordism is very vague. “it is not clear whether it refers to a variant of Fordism, in which case its novelty is dubious, or to a ‘yuppie’ regime of accumulation, in which case its empirical relevance is suspect. The elements of neo-Fordism, like those of Fordism, are hardly new”. Clarke goes on to claim that these elements can be found in nineteenth century British industry. We would like to claim that some of these ideas are even older than Clarke says. “Division of labour (and simplicity of operation during production), however, so far as it can be introduced, occasions, in every art, a proportionable increase of the productive powers of labour” (A. Smith, “The Wealth of Nations” Everyman’s Library editions 1910, reprint 1964, vol. 1 pp 5-6), where he describes an ‘ideal’ pin-making industry, mentioning the need of different operations for each worker. Despite the lack of clarity in terms, and the existence of such industry functions as early as the late eighteenth century (if not before) we think that the distinction between Fordism and Neo (or Post)-Fordism is rather clear as far as the needs of our Thesis are concerned.

\textsuperscript{26}While for Psychopedis (in Bonefeld, Holloway 1991 ms p. 7 ff) the concepts of Fordism and Post-Fordism are not theoretical categories but simple descriptions of society and social relations.

\textsuperscript{27}This indicates that L. Beveridge was in the Liberal/Utilitarian argument, and a follower of J. S. Mill’s ideals, who claimed that “it is better to be Socrates dissatisfied, than a pig satisfied” and introduced a ‘quality’ element to the notion of happiness.

\textsuperscript{28}See the paragraphs on reproduction and on the ‘need’ of reproduction.
private property of the ruling groups and brought the former under public control. Δ. Καραγιώργας (undated, circa 1979-80 p. 103 ff) goes beyond the (O'Connor) definition of public property to define public good (or utility) as the utility which, when existing in a society, can be used by each member of it simultaneously without the use by one member obstructing the ability of other members to use it. Or, in other words 'a utility can be called public if each one has at his/her disposal a quantity equal to the total. \( X_A = X_B = X_{TOTAL} \) (p. 104, our translation). Though Καραγιώργας mentions state policies other than the welfare state we would like to suggest that the development of the KWS and of the NHS in particular in Britain make those services ‘public utilities’. And as Καραγιώργας mentions since it is almost impossible to exclude users from a public utility the production and provision of those utilities cannot be undertaken by a private enterprise (ibid. p. 108).

Reproduction.
This is one of the most crucial or even the most crucial and important term of the whole thesis. Analysing the term clearly and adequately will help us support our hypothesis about the contribution of reproduction to the continuation of capitalism.

The three components in order to achieve production and capitalist production, in particular, are: firstly, instruments of production, which will be used to convert raw materials (which is the second component), to use values (which is the outcome of the whole process of production); secondly, raw materials which will be transformed by labour power (which is the third component) to use values; and thirdly labour power, which will add its value to the value of the raw materials and transform it to use value (Mill 1868 pp. 15, 34-35 and Marx 1967 p. 43). In the capitalist mode of production, raw materials can be found in nature, the instruments (or means) of production are owned by the capitalists and

"by labour power or capacity for labour is to be understood as the aggregate of those mental and physical capabilities existing in a human being, which he exercises when ever he produces a use value of any description.” (Marx Capital 1967 V. I p. 167)

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29 The Greek term 'αγορά' can be translated either way.
30 The issue of public utilities is very much analysed by New Right theorists as well, who cite the 'Pareto optimal circle' for the use of public utilities. The two definitions (Καραγιώργας belonging to the Marxist school) do not differ much.
31 Mainly defence, flood prevention public lighting, traffic regulation etc.
32 In the case of NHS in Britain this is historically contingent and determined since it is the outcome of class struggles (this issue will be discussed later on in this chapter and in Part III 'Conclusions'). However, this does not change our observation of the NHS as a 'public utility'.
This labour power exists only in the living selves of the human beings (p. 169)\textsuperscript{33}. Or "as William Petty puts it, labour is the father and the earth the mother" (ibid. p. 43). O'Connor (1973) uses the term 'human capital', which

"consists of teaching, administrative, and other services in all levels of the education system and scientific and R&D services both inside and outside the education establishment" (O'Connor, 1973, p. 101).

Though in this case we are in full agreement with O'Connor, we think that his definition is incomplete as he does not include the very issue of health and maintenance of the productive capacity of the workforce (as far as health is concerned)\textsuperscript{34}. The instruments of production get destroyed (during the process of production itself), either due to wear and tear, or due to 'metal fatigue'. Last but not least, there might be a demand for their 'modernisation' so they can assist better in the production of use values more favourable to the market\textsuperscript{35}, or even more important the 'modernised' instruments of production can contribute to the creation of new industrial relations and forms of work in the workplace itself\textsuperscript{36}. The instruments of production, though, have to be in a certain productive capacity, so as to offer such an amount of use values to the market (or a certain type of worker on the shop floor level), so the profits of the capitalists can be maximised. In this sense, we call reproduction (of the instruments of production) the part of production necessary to replace the amount of the constant capital destroyed (or just been outdated) during production (so productive capacity will either remain stable, or will be fixed according to the needs of the market or of the organisation of production).

Equally, we call reproduction of the labour power the function (during the process of production but out of it as well), which maintains a required amount of capacity of the labour power adequate for the needs of production, and capable and willing to work in the transformed workplace (in order to achieve new

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33 See M. Itoch 1980, p. 61 as well. Itoch relates consumption by the labourers to reproduction and claims that "these means of substance represent the embodiment of a certain quantity of labor time necessary to produce them" (ibid).

34 See ibid. page 111 as well (about education being the most costly social service in the US), where there is no mention of health again.

35 This does not mean that the market acts autonomously. The demands are highly influenced by the capitalists - through advertising, consumer ideology etc. - who try to impose styles of living 'favourable' to their products; equally though, the consumers are not 'string puppets' in the hands of the capitalists as they self interpret the messages sent from the capitalists.

36 See the discussion of Holloway's "Red Rose of Nissan" earlier in this Chapter.
By the term *adequate* we mean that the number of people willing and able\(^3^8\) to work in the places of work offered by the capitalists under certain conditions and for certain wages proposed by the capitalists (or even slightly negotiated) is equal or larger (in which latter case we have unemployment according to J.M. Keynes)\(^3^9\) than the number of the workplaces available at a particular moment.

The labour power does not only have to be reproduced in adequate quantity (we assume the skills as an 'economic'\(^4^0\) matter). There must be a particular political quality as well. The labour power has to be reproduced as such (as C. Offe puts it in his “Contradictions of the Welfare State”). That is to say that the labour power has to be obedient and willing to offer itself under the conditions suggested and imposed by Mr. Moneybags. As set by J. Agnoli (“Die Transformation der Demokratie”; Greek edition “Ο ΜΕΤΑΣΧΗΜΑΤΙΣΜΟΣ ΤΗΣ ΔΗΜΟΚΡΑΤΙΑΣ” ‘ΕΠΙΚΟΥΡΟΣ’ ed Athens 1972) the labour power has to be properly specialised (or what we call ‘economic’\(^4^1\) element), and manipulated and obedient (or what we call ‘political’\(^4^1\) element).

The process of reproduction (of labour power) can be divided in two:

a) The short term reproduction is aimed at the maintenance of the productive capacity of the existing labour power. So, it consists of nutrition habits and abilities, relaxation and recreation (and self recreation) opportunities, and retraining schemes, if these are short term\(^4^0\).

b) The long term reproduction is aimed at the creation of the workforce for the future. So, it consists of policies to bring up children, and to train them in such a way, as to be both in adequate numbers and well skilled and obedient to work in the workplace of the future\(^4^1\).

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\(^3^7\) See Aglietta 1979, pp 179-180. Aglietta makes an interesting distinction between reproduction and consumption. While they both aim at the ‘reconstruction’ (Aglietta’s term) of the labour power, consumption is private, while reproduction is public and mainly state regulated (see ibid. p. 156. as well).

\(^3^8\) By ‘willing’ we mean obedient, and by ‘able’ fit, properly trained, efficient etc..

\(^3^9\) This question has been better approached in Chapter 2 which is more relevant the theory of J.M. Keynes.

\(^4^0\) Which is similar to Aglietta’s ‘consumption’. See Footnote 33, above.

\(^4^1\) Stressing his idea to its limits, we can suggest that there might be a rational relation (in other words planning or pursuit) between the cuts in the child benefits and the lower number of workers required in the factories of the future. For which policies should be included to the understanding of ‘reproduction’ see Aglietta 1979 p. 180 as well.
We want to suggest that in order to achieve adequate reproduction\textsuperscript{42}, it is important for the capitalists to control both short and long term reproduction:

a) by observing the short term one and intervening to a small degree in order to 'reguide' the process (in terms of training schemes/techniques, or of inadequate recreation, so potential decline in productivity etc.) of reproduction and

b) by regulating and influencing the long term one, observing the results of the policies and intervening again to 're-regulate' the process.

So, reproduction is an economic and political process consisting of various short and long term policies, aimed at the maintenance and creation of labour power (ie human labour) which is adequate for the needs of capitalist production.

\textsuperscript{42} Reproduction hereafter takes the narrow sense of 'reproduction of adequate labour power as such' (see footnotes in Introduction as well).
SECTION 2:
“Discussion of Current Theoretical Approaches”
This section will discuss the current theoretical approaches to the welfare state and the capitalist state in general. In a sense, we will try to bring the definitions of section one together and examine their interconnections. There are two main theoretical approaches discussed in this section; the ‘Capital Logic’ school and the critique to the ‘Capital Logic’ school raised by Bonefeld, Clarke and Holloway. The section discusses first the necessity of reproduction for capitalist economy, then the (possible) ways to achieve it and the importance of the welfare state in this area. It is exactly this approach that Bonefeld Clarke and Holloway criticise as functionalist, in the closing paragraphs of the section.

a) The ‘Need’ of Reproduction.
L. Althusser claims (in his ‘Ideology and Ideological State Apparatus’) that, the ultimate need of production is the reproduction of the means of production. From our point of view this understanding of the needs of production is incomplete, as the need of the reproduction of the relations of production is not explicitly included in the statement. Our first task in approaching this issue is to approach the term ‘means of production’. As we have already seen at the beginning of this chapter, the means of production are the instruments which the labour power uses in order to convert raw materials to use values. The part of the capital consisting of the means of production, the raw material, auxiliary material and the instruments of labour is called by Marx ‘constant capital’ as it does not undergo any quantitative change in the process of production.

“On the other hand, that part of capital, represented by labour power, does, in the process of production, undergo an alteration of value. It both produces the equivalent of its own value, and also produces an excess, surplus value, (...). I therefore call it the variable part of capital or, shortly variable capital” (Marx 1967 Vol. I p. 209).

Even more importantly, labour power (which as previously mentioned exists only in the living self of humans) is the only commodity “whose use value possesses the peculiar property of being the source of value” and its consumption results into the creation of value

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Moreover this is an incomplete understanding of capitalism. Purpose and pursuit of capitalism are the expansion of the invested capital, or as Aglietta 1979 sets it ‘the production of surplus value is an internal necessity of capital’ (p. 51). Reinvestment of profit is the prime requirement of capitalism, and as Weber has observed, capitalism is characterised (and distinguished from other modes of production) by the continuous reinvestment of profit. Thus, Althusser, is more close to a Weberian understanding of capitalism than a Marxist one and by failing to see that the purpose of capitalism is the expansion of capital through the extraction of surplus value, fails to see the contradiction (this contradiction being between purposes and requirements -as we will see later in this section-) of capitalism itself. However we use this understanding as it provides us with a good first step for the approach to the issue of reproduction.
This unique capacity of labour to produce and enlarge value makes it a special commodity in the process of production and as Marx has claimed since the '1844 Manuscripts' “the demand for men necessarily governs the production of men, as of every other commodity.” (MECW vol. 3 p. 235, emphasis in the original). Later on in this manuscript he argues that “Labour produces not only commodities: it produces itself and the worker as a commodity” (ibid. p. 272). The existence of the worker depends on capital (second manuscript, opening pages), however the worker is important for the capitalist himself as “the capitalist can live longer without the worker than can the worker without the capitalist” (first manuscript, ibid 235). What is important from our point of view is the implication that the capitalist cannot live without the worker, as extraction of surplus value is a sine qua non for capitalism and the sole source of surplus value is the worker him/herself. Thus, there is a need of adequate labour power at any moment in the process of production. In this sense while some other commodities ‘may’ (are ‘allowed to’) disappear from the process of production and circulation (especially as long as they can be replaced by other eg oil instead of coal, and uranium instead of oil for energy production), labour power ‘may not’ disappear. This ‘peculiarity’ of labour power makes its reproduction (ie the reproduction of the human being possessing it) a sine qua non for the whole process of production and especially for capitalist production, which bases its existence on the extraction of surplus value from the labour power (see Capital p. 172).

Such an approach to the necessity of the reproduction of labour power can lead to a functionalist understanding of state policies, political developments and politics. At this point we would like to stress that such an interpretation of Marx and of the problem of (re)production of labour power is misleading, because it takes account of only one factor of the formation of policy, viz. the need for reproduction. However, it mentions nothing about the form such a reproduction will take. As wage is the cost of maintenance and reproduction of labour power on the one hand (Capital vol. 1), it is however “determined through the antagonistic struggle between capitalist and worker” (‘First Manuscript of 1844’, MECW vol. 3, p. 235) on the other. It becomes clear that the development of policies also depends on factors other than the needs and requirements of capital. Additionally, (however important) the quest for reproduction is, it is just one of the pursuits of the state. “It goes without saying that the proletarian, ie the man who being

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44 The main argument in the first of the 'early manuscripts' though is alienation and estrangement during capitalist production, since the worker has no control over his/her labour and product of this labour.

45 On the other hand as Itoch (1980, p. 61) mentions, "labor power cannot be produced in the labor process. It is essentially the subject and not the object in any form of society". See J. Hirsch in Holloway Picciotto 1979 p. 60 also.
without capital and rent, lives purely by labour, and by one sided, abstract labour, is considered by political economy only as a worker. Political economy can therefore advance the proposition that the proletarian, the same as any horse, must get as much as will enable him to work. It does not consider him when he is not working, as a human being; but leaves such consideration to criminal law, to doctors to religion, to statistical tables, to politics and to the poor-house overseer” (ibid. p.241). Thus, we have a clear distinction between political economy on a narrow sense and politics (and law etc.). It is here that the functionalist argument shows its shortcomings. What could be ‘functional’ for political economy is not ‘deterministic’ for politics. Law, ideology, and class struggles and alliances are additional factors that influence policy making and politics. This presents us with the problem of ‘how to (re)produce (and maintain) labour power?’

b) How to Achieve Reproduction? And who should pay for it?

We will approach this question by examining the concept of the ‘cost’ of reproduction first. As we have claimed earlier, in the process of achieving both short and long term reproduction there must be a certain amount of use values consumed. In other words a certain proportion of production has to dedicated to reproduction. The questions arising from this approach are: a) what is the cost of reproduction, ie which is the part of production to be absorbed in reproduction? are there any factors that determine this cost and which are they? and b) who has to pay this cost?

As we mentioned in the previous paragraph, for Marx the cost of the labour power is the cost of its production ie its reproduction. The necessary means for the production of the labour power must include the cost of the means of production of his offspring as wage labourers

(57 (ibid. p. 171). In this sense, we will go a step further from Marx’s analysis in the sixth chapter of the first volume of his ‘Capital’, to suggest that the cost of the labour power does not take only a clear wage form, but that there are other forms the cost of labour power can take. (Such as free training schemes -short term- or free school meals for the off-spring of the worse off -long term- etc.).

It has to be clearly understood though, that these policies and the cost of reproduction are not fixed and eternal. They are dependent on the habits of each society and on the demands the working class raises for its way of perpetuation and last but not least on the strength of the working class when postulating their demands. Reproduction can be achieved either under the conditions described by Engels in the ‘Condition of the Working Class in England’ or under the conditions of relative prosperity as in the mid-1960s. Once again we

46 This question will be approached in the next paragraph of this chapter. And finally answered in Part III, Chapter 1 ‘Conclusions’.

47 This could be included in our understanding of the long term reproduction.
will emphasise that the standards of living of the working class are an outcome of the level of class struggle (and its ability to create results favourable to the working class) in each capitalist society.

Up to now we have examined the term reproduction, the importance of reproduction for the whole capitalist mode of production and we have related the cost of the labour power with the cost of its reproduction. In this paragraph of the chapter we will try to examine the various ways to achieve reproduction and its determinants.

In any particular mode of production we can have different norms of production and different forms of state depending on the class relations, the accumulation process and the development of the forces of production. Equally, in the same mode of production (and in our case this mode is capitalism) we can have different ways of reproduction of the labour power, (depending on the factors already mentioned) which of course will provide us with an understanding of the form of state.

A brief examination of the ways of reproduction in the states of the capitalist mode of production can provide us with a huge spectrum of possible policies.

As previously mentioned, this spectrum can include conditions from Victorian conditions of living to apartheid oppression at the one end of the spectrum, to Keynesian welfare state and policies of social democracy on the other.

Contemporary (post war) British politics show that reproduction is achieved through state intervention which decreased after 1979 (and there is a potential of a substitution of it by other ways of state intervention -see eg the New Right ideology, the anti unionist legislation the activity against strikes etc.) but in no instant can be understood as having been abolished.

Does this mean that in a modern social and economic system with a highly sophisticated division of labour society is unable to reproduce itself without any state assistance or intervention? Is it that the individual ways of the Victorian era are inadequate from now on to assist in the reproduction of the working class? So, is it that a third part should take action over the issue? And even more is it that this third part should be the “committee for managing the common affairs of the whole bourgeoisie” (Marx Engels 1976 Vol. 6 p. 486)? In other words, is it that in a modern state we might have inadequate reproduction without any state intervention? What can be the reason of the inadequacy of the ‘old ways’? Is it that the new structure of society (nuclear family -and even break of it-, urbanisation, social relation depending on the workplace and not on neighbourhood etc.)

48 Similar to those J.S. Mill suggested; see Chapter 2.

49 This problem will be examined in more detail and in relation to applied politics in the next few pages dealing with ‘Critique of the Welfare State; Keynesianism and Fordism’. Here we restrict ourselves to an exposition and theoretical grasping of the questions. For the descriptive definition of the welfare state see Chapter 2.

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developed out of modern capitalism, sounded the knell of the 'traditional' Victorian way? Ian Gough (1979) relates the adoption of certain regulatory policies to capitalist development. As evidence for his argument he refers to the nineteenth century 'Public Health Acts' and to the 1909 Housing and Planning Act which regulated health, vaccination and sanitation, town planning and house building etc (pp. 36-37)\textsuperscript{50}. The need for securing reproduction is one of the reasons for the adoption of welfare policies. The other is the level of class struggles, which is examined later on in this chapter. Both the need of reproduction and the way to achieve it though, take specific forms in specific cases, due to the special workforce each norm of capitalism requires for the successful extraction of surplus value. As we discussed earlier in this chapter, the norm of capitalist production which prevailed during the post war period\textsuperscript{51} has been called 'fordism'. A number of scholars\textsuperscript{52} have related the fordist norm of production with the Keynesian Welfare State form of state and reproduction, and the state itself with internal needs of capitalist economy\textsuperscript{53}.

c) The welfare state as a factor of reproduction.
In this ‘paragraph’ we will examine in detail the reproductive functions and aspects of the Keynesian Welfare State in a modern economy; additionally we will make references to interventionist policies of the nineteenth century and their Marxist interpretation.
The first Marxist interpretation of state intervention in capitalist economy\textsuperscript{54} exists in the treatment of the regulation of the working day in the tenth Chapter of the first volume of 'Capital'. There was state intervention in reduction of the length of the working day (which was achieved in stages throughout the nineteenth century) mainly due to class struggles, which ended up being (according to Marx) beneficial for the bourgeoisie as it reduced overexploitation. “J. Leach deposes: ‘Last winter six out of nineteen girls were away from ill-health at one time from over-work. I have to bawl at them to keep them awake’”

\textsuperscript{50} ‘The city is as necessary to capitalist reproduction as the factory is to capitalist production’ (ibid. 37, cited from C. Cockburn ‘The Local State’).
\textsuperscript{51} Especially in Britain and the other main industrial countries.
\textsuperscript{52} Mainly the ‘German Derivation’ School (Altvater, J. Hirsch, Muller and Neussus, Jurgens, Blanke and Kastendiek, et al), the ‘French Regulation School’ (Aglietta, Palloix) and in Britain scholars as Gough and Holloway.
\textsuperscript{53} Especially the school of German Derivation. German Derivation and French Regulation are usually grouped together in the ‘Capital Logic School’.
\textsuperscript{54} And perhaps the first state intervention in capitalist economy.
Another striking example of exploitation is given a little later in that chapter with the case of the Marylebone blacksmiths who are calculated as 'numbers of blows they can give in their lifetime' (p. 256), while the problems that can occur are mentioned in reference to a railway accident in which the overworked train crew reported that after 50 hours of work "their labour power failed...Their brain ceased to think, their eyes to see" (ibid. p. 253). One of the very first regulations of adult labour was this of the baking workers in Ireland in 1861. The Committee of the British government believed that there were natural laws that limited the working day and "that any constant work beyond 12 hours a-day encroaches on domestic and private life of the working man and so leads to disastrous moral results...has a tendency to undermine the health of a working man, and so leads to premature old age and death..." (p. 252).

Thus, the productive capacity of the workforce gets worn-out sooner and there can be a problem in the reproduction of this productive capacity. "It would seem therefore that the interest of the capital itself points in the direction of a normal working day" (ibid. p. 266 our emphasis). We believe that this argument can be extended in order to incorporate the creation of 'active' policies that will enable the maintenance and reproduction of the productive capacity of the workforce. These policies will not just hinder the capitalist class from the overexploitation of the workforce - in other words limit the rate of surplus value- , but will take positive action for the maintenance and reproduction of the productive capacity of the workforce and give the burden to the capitalist class either in the form of higher wages (ie greater cost of variable capital) or in form of greater taxation (which can be analysed either as higher cost of variable capital, or reduction of the surplus value extracted).

Such an approach does not mean a deterministic or a functionalist understanding of the welfare policies. Though their results can satisfy demands for reproduction or legitimacy of the existing order and system of distribution of privileges (and subsequently these policies can be adopted in anticipation of their results), the will of their actual 'creators' can

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55 Another factor that influences productivity is illiteracy and the lack of skills. Though Marx makes a rather prolonged empirical approach to the issue of illiteracy of the working class children of nineteenth century Britain (ibid. 259-260), his approach tends to show more the plight of the working class than the effects this lack of knowledge and skills had on production, a matter which he does not tackle adequately. Moreover, he makes no reference to the issue that the industrialist could not educate and skill their employees themselves as we will claim later in this chapter.

56 Original quotation from Report of Committee on the baking Trade in Ireland for 1861.

57 Marx claims that "the value of the labour power includes the value of the commodities for the reproduction of the worker, or of the keeping up the working class." (ibid). See Part III, Chapter 1 'Conclusions'.

58 This is related to class struggle. See next section.
be based on different reasoning and pressures. Marx refers to the ‘struggle for the (imposition of) the normal working day’ bourgeois reformists and philanthropists, and trade unions and the Chartists had to put up in order to reduce the length of the working day. Though as we saw earlier, avoiding the over-exploitation of the workforce works to the benefit of the capitalist bourgeoisie, the establishment of the normal working day was neither ‘automatic’ nor a bourgeois initiative but “the result of centuries of struggle between capitalist and labourer.” (Capital p. 270). As for the adoption of ‘active policies’ in order to secure reproduction, which we mentioned earlier, the idea was supported by various physicians in 1835 who told the House of Commons of the necessity of the imposition of legislation to avoid premature death (p. 280) and by the London Times recognised the importance of such policies as early as November 1861 by saying that

“though the health of a population is so important a fact of national capital, we are afraid it must be said that the class of employers of labour have not been the most forward to guard and cherish this treasure” (p. 270 footnote 1, our emphasis)59.

This negligence by the capitalists indicated in the Times quotation makes the relevance of what we called ‘active’ policies adopted by the state to capitalist reproduction clearer. The question now is to define and understand these policies. As classical Marxism assisted in the understanding of the need of reproduction and in the theorisation of the emergence of the first interventionist policies during primitive accumulation (by the combination of class struggles and functional needs of the bourgeoisie which -however- the bourgeois never considered) contemporary Marxist theories will help us understand the modern welfare state. Gough in his ‘Political Economy of the Welfare State’ (1979) defines

“the welfare state as the use of state power to modify the reproduction of labour power and to maintain the non working population in capitalist societies” (pp. 44-45 emphasis in the original)60.

Thus, the welfare state is a set of policies which are more or less different in each state -and possibly related to the norm and requirements of capitalist production (as Altvater, Hirsch, and Muller and Neussus suggest), and to the level of class struggle in that state61 (our

59 All these references indicate the importance of empirical research for social sciences and strengthen the claim that Marx and Engels (in the ‘Condition of the Working Class’) relied on empirical research and observation in order to create their theories.

60 The reader should notice that in our thesis we will use the term ‘maintenance’ in a different way, as ‘maintanance of the health of the working population’. Additionally, for non Marxist definitions of the welfare state (mainly descriptive ones) see next chapter on the construction and reconstruction of the welfare state in post war Britain.

61 See Chapter 2 and next section of this chapter.
suggestion).
Earlier in this chapter we examined reproduction as a ‘sine qua non’ for capitalist production. Now we will turn to the cost of reproduction and the possible ways of achieving reproduction (or in other words the question who has to pay for the cost of reproduction) and the determinants of the choice of the way available. This will make our definition of reproduction (and even more of the policies to achieve reproduction) more related to the problems of the British state, society and politics and in this sense more operational for our thesis.

As mentioned just before, the activities of the welfare state according to Gough can be divided into two. Firstly; activities pursuing the reproduction of labour power (or what we call in our thesis ‘reproduction’), and to activities concerned with the maintenance of the non productive population ie the elderly, the mentally ill and the mentally handicapped, the disabled, the children etc. From our point of view the first category is more interesting. It comprises several policies, such as the regulation of food quality and additives, subsidising certain services such as housing education and training and last but not least the National Health Service (Gough, 1979 pp. 45-46).

For O’Connor (1973, p. 64) the difference between the state and capital in the organisation of production is that the state does so after a political decision, whereas capital does so in the pursuit of profit. And he goes on (ibid. p. 77) to mention that it is very difficult to create a national consensus on the level of spending. Thus (and if we accept that certain functions regarding the (re)production of human capital or of the productive capacity of the workforce are not profitable since they are not directly involved in production as we claimed earlier), the question “under which ‘logic’ does the state take its ‘political decisions’?” arises. Holloway and Picciotto (1979, p. 19-20) when referring to Muller and Neussus mention that they derive the state from the need capitalist society has to be protected from its own (self)destruction, due to the unlimited desire of capital for extraction of surplus value. As Altvater (in Holloway, Picciotto 1979, p. 42) sets it “the state takes on functions for the preservation of capitalist society”. As Norman Gensburg 1979 claims

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62 Though we broadly agree with such a division of the welfare state, we disagree with the inclusion of the children in this category, because they form the workforce of the future and not the ex workforce (pensioners) or the ‘unrecoverable’ workforce (handicapped and disabled). Gough himself sets education (which is the main service to children) in the first category of ‘reproduction’. We believe that the rest of the welfare policies concerning children should be in that category also.

63 The second category consists of pensions and social security benefits, superannuation schemes and in general of policies ‘for transferring part of the social product from the direct producers to these groups’ of the population unable to work (Gough 1979, p. 47).

64 Who are based in the analysis of the British nineteenth century Factory Laws Marx makes in the first volume of Capital.
"the existence of the welfare state is thus essential to the survival of capitalist society, not least because it ultimately prevents the exhaustion and destruction of the labour force by capitalist competition" (but because it a coercive power also)\textsuperscript{65}.

While most of the German Derivation School\textsuperscript{66} mention self-destructive elements of capitalism and limits imposed by the state to be the 'werewolf desire' for fresh labour and the Factory Laws respectively\textsuperscript{67}, O'Connor comes closer to contemporary times and mentions that the development of capitalism has destroyed the very informal foundations of society (local community, clan, family etc.) that offered some reproductive functions in the pre-industrialist economic structures (oc 124), while this point has to be matched with his remark that monopoly capital causes the impoverishment of the working class so the needs this class has to be reproduced require state action (oc p. 27)\textsuperscript{68}. As previously mentioned capitalism brought the separation of public and private property and interests. For Muller and Neussus (oc. 36-37) this separation subsequently created the separation of the state from society and actual commodity production. The state is not a real, but an ideal collective capitalist, while the interest of capital for the working class is only subsequent, after the existence of the labour producers was jeopardised.

"Social policy' (ie state activity intervening \textit{ex post facto} in society and seeking to resolve its 'social problems') thus has the characteristics, down to the smallest details, of a process of paternalistic supervision, control of the 'welfare' of the producer. (This is felt by every worker who has to wait in the queue to see the medical official, the bureaucrat who certifies him as fit to work, or who repairs his labour-power as quickly as possible)\textsuperscript{69}.

\textsuperscript{65} Norman Ginsburg, "Class, Capital and Social Policy" MacMillan London 1979. The book concentrates on housing policies and approaches them as an outcome of class struggles (mainly see p. 106, 116 and 117, and 168) and reproductive needs of capital (in a lesser extend see p. 109). Ginsburg's work is important for this thesis because he is influenced by German Derivation and applies this theoretical framework to concrete policies of the welfare state assisting reproduction (these policies being housing). Though Ginsburg gives primacy to class struggles, the methodological similarity with our approach (application of theoretical frameworks to concrete policies) is apparent.

\textsuperscript{66} As presented by Holloway and Picciotto 1979.

\textsuperscript{67} As Muller and Neussus (in Holloway, Picciotto 1979, p. 38) mention, Marx derives the "particularisation in factory legislation" from the catastrophes that the extraction of surplus value entails for living labour which is the real producer of surplus value.

\textsuperscript{68} One of the most important issues in O'Connor's book is related to this point. Due to the impoverishment of the working class the state has to buy the surplus product either by making investment (eg roads, railways) or by creating a large welfare or a large warfare state (and indeed by combinations of these). This argument though interesting is out of the actual research pursuit of this Thesis (viz. the importance of the Welfare State -and the MHI in particular-) so we will not analyse it further.

\textsuperscript{69} Ibid. pp 38-39, emphasis in original. Muller and Neussus observation of the health service is of particular importance for the Thesis. It is closely related to what we call a Mode of Health Maintenance. However the definition of social policy as an \textit{ex post facto} action is inadequate as it excludes the cases of education, training, preventive medicine etc.
Hirsch contrary to this derives the state more from capitalist relation and class struggles, than from the needs of capital. For Hirsch it is both the strength of the working class and the exhaustion of the labour power of the worker during production that force the state to undertake certain (welfare) policies (cf. Holloway Picciotto 1979 p. 24, and Hirsch in Holloway Picciotto 1979 pp. 84 ff) 70. Though the approaches by Altvater, and Muller and Neussus are more elaborate on the actual needs of capitalist production and the necessity of capitalism to be protected against its self-destruction, Hirsch’s point is more important because it includes the issue of class relations and struggles 71 so it is less functionalist.

From our point of view, we have to relate the Fordist norm of production to the Keynesian way of reproduction, because the needs for semi-skilled labourers are bigger, mass production requires low absenteeism and occupational continuity in the workplace (ie low death rates), more money is ‘invested’ on the training of particular people, and their loss will mean cost of training others to replace them, and last but not least the agrarian reservoir of potential manual workers has become smaller as urbanisation has shown a decline. (see Hirsch in Holloway, Bonefeld, forthcoming 1991, ms p. 14). So, the intervention of the state in the post war Britain was greatly required 72, and because of the reasons examined in more detail (working class militancy, swing to the left, liberal - Fabian ideology) in the next chapter, the way of reproduction ‘chosen’ was the one which used Keynesian policies, and the form of state adopted was the post war British consensus state. The modern welfare state policies have got a strong ideological and moral 73 basis, which is set out explicitly, even in the “Beveridge Report” and the “Full Employment” themselves.

However, there is a problem arising from such an observation of the welfare state and of state policies in general. This is the action of the state which pursues to limit capital for the very sake of capital, on the one hand and the cost of these limits on the other. The policies

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70 As for the origins of the approach in classical Marxism see, ‘Capital’ vol. 1 p. 283 and 284.

71 See Holloway (in Bonefeld and Holloway 1991 forthcoming ms. 136) as well, about Hirsch trying to break with the ‘Capital logic school’ as early as 1974/78. We will elaborate on this critique (about lack of class struggles element in German Derivation) later on in this chapter, when we will discuss the critique of the ‘Regulation’ and the ‘Reformulation’ theory by Bonefeld, Clarke and Holloway.

72 According to this theoretical approach.

73 See Chapter 2, the sections on ideology, and in order to refer to more recent approaches on the issue, we can mention Bryan Harvey’s “Alexander Redgrave Memorial Lecture” in 1972 (See Empl. Gaz. 1972 pp. 695 ff). In this argument we can see how ideology can influence political decisions about changing legislation concerning factories. The issue of safety is central because people deserve safety in their workplace and not only for the reason that their injury can be expensive for capital. Such an approach helps in proving our point that it is not only the functional needs of capital that form the laws and the state’s policies but a variety of factors. These decisions can (and usually are) functional for capital but the intention of their inventor/suggesting person or agency is not necessarily to serve capitalism See Empl. Gaz. 1973 p. 664 (about EEC and safety regulations) as well. Major contributor to the choices can be ideological assumptions of the time and place etc. This is the very reason we have included an overview of the New Right Ideology in the next chapter.

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of the preservation of the working class (either through the Factory Laws in the nineteenth century, or by the creation of the KWS after the war) are expensive for capital, either due to the limits of exploitation, or through taxation, in order to fund the welfare state. Additionally, as Gough (1979, p. 118) remarks, the welfare state reduces the number of workers for capital. This is the line of thought followed by Claus Offe in his ‘Contradictions of the Welfare State’ (London 1987). For Offe “[a] contradiction is the tendency inherent within a specific mode of production to destroy those very pre-conditions on which its survival depends” (p. 132 our emphasis). Offe cites as such the various ‘effective’ state policies which put a burden on capital (ibid. p. 126), and the welfare state in particular “the contradiction is that while capitalism cannot coexist with, neither can it exist without the welfare state” (p. 153, emphasis in the original). In other words the securing and perpetuation of capitalism is expensive for capital itself.

From our point of view, Offe’s analysis of the welfare state is not incompatible to the German Derivation and the French Regulation Schools. Indeed we would like to include him in the broader ‘Capital Logic’ school. As with German Derivation and French Regulation, the state adopts policies due to the needs and requirements of capital in Offe’s theory. The difference from the other two schools (which is Offe’s main contribution to our understanding of the state policies) is that he examines the policies as contradictory due to contradictions in the capitalist mode of production. Offe shows that the ‘logic’ of capital is contradictory, because capitalism is itself contradictory. This is Gough’s opinion also as he argues that “it is not the Marxist analysis of the welfare state which is contradictory, but the welfare state itself” (p. 11). However, the contradiction here as set by Gough does not have exactly the same meaning as when used by Offe. The meaning given by Gough is more related to the ‘Janus-faced’ conception of the welfare state. Gough goes closer to Offe’s understanding when he justifies the use of the term:

“To concentrate solely on its ‘positive’ aspect,......, is to lose sight of its repressive, capital oriented side. But equally to concentrate on its ‘negative’ aspect,......, is to lose sight of the very real gains a century of conflict has own.(......) Given the universal growth of welfare state in advanced capitalist countries, a second contradiction has now developed. The very scale of state expenditure on the social services has become a fetter on the process of capital accumulation and economic growth itself.” (p. 14)

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74 We will return to this crucial issue in Part III, Chapter 1 ‘Conclusions’.
75 See pages 64-65 and 105-108 also, dealing with the issue of expansion of the welfare state as a hindrance to accumulation.
Thus, both Offe (1974) and Gough (1979) argue that there is a contradiction between the welfare state and capitalism.

Though we agree with such an observation of capitalist economy and social policy under capitalism, we believe that both Offe and Gough fall short of a full and in depth analysis of the issue. Our opinion (which we will analyze in the end of this Thesis, Part III, ‘Conclusions’) is that the contradiction is not in the welfare state, or between the welfare state and capitalism but that there is a contradiction in capitalism between the extraction of surplus value and the securing of the perpetuation of this extraction, especially in the Fordist mode of production due to the reasons analyzed above (fordism has destroyed the traditional forms of reproduction).

d) Critique by Bonefeld, Clarke and Holloway.

After examining the theoretical premises of the Capital Logic school (especially the German Derivation) and the importance of the issue of class struggle for us, we would like to turn to a critique of German Derivation and Capital Logic in general. The mistake or incapacity of the ‘German Derivation School’ (and of the ‘Capital Logic’ School in general) is that it takes no (or very little) account of the totality of political society and of political economy. Focusing only on the ‘functional’ needs of capital accumulation and capitalist production, it neglects the important aspects and factors of class struggle and History.

Bonefeld 1991 (in forthcoming Bonefeld and Holloway) makes a distinction between the Regulation approach and the Reformulation of state theory offered by Aglietta, et al and Hirsch et al respectively. As Bonefeld mentions “the reformulation aims to overcome the slowdown of the state derivation debate in the 70s” (Ms/Cap/class 33, p. 96) Bonefeld’s critique is that neither French Regulation nor its reformulation manage to address the issue of class struggle, as French Regulation is concerned with the attempts by the state to prevent capitalism from its own collapse (as discussed earlier), whereas the interest of the Reformulation approach lies in the accumulation regime (oc pp 98-100). Bonefeld’s critique is that the Reformulation School fails to show the crucial importance of class

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76 However, we do not agree with the analysis of class struggles as a ‘contradiction’ of capitalism. Class struggles are an element of capitalism which hinder further exploitation. They are caused by capitalism but not ‘necessary’ to it.

77 The seeds of such a theory exist in the fifth section of the tenth Chapter of Capital. Marx remarks that “in its blind unrestrainable passion, its were-wolf hunger for surplus labour, capital oversteps not only the moral but even the merely physical maximum bounds of the working day....It attains this end by shortening the end of the labourer’s life, as a greedy farmer snatches increased production from the soil by robbing it from its fertility” (pp. 264-265); and “workmen and factory inspectors protested on hygienic and moral grounds, but Capital answered: ‘my deeds upon my head! I crave the law/The penalty and forfeit of my bond’” (p. 287). This citation is important for an additional reason. It indicates an alliance between the working class and the then (1844) under creation state regulation and embryonic welfare bureaucracy.
struggle to the formation of politics and "fails to specify the state as object and result of class struggle" (109) and sees class struggle as subordinate to the factors regarding the formation of politics and the state and not as the primary motor of historical development (121 ff).

As Simon Clarke (in Bonefeld, Holloway oc ms 111) claims (in agreement with Bonefeld), the regulation theory

"recognises that economic relationships are socially regulated, but the regulation of social relationships is still subordinate to the functional requirements of the expanded reproduction of capital. Thus the regulation approach stops short of a sociological critique of economics, and fails to develop a Marxist critique of political economy".

In his article Clarke, claims that it is the class struggles that are predominant as the driving force of history, a trail followed by Holloway's contribution to that volume as well78 while in his subsequent contribution ('Capital is Class struggle') which is a reply to Jessop, Holloway mentions that class struggle is 'grinding and unspectacular' (ms p 2/188).

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78 While B. Jessop (in the same volume) criticises Holloway's position and insists that in our analyses we should give predominance to the categories of "commodity value money and capital and their articulation before we can even begin to grasp the significance of particular class struggles" (Ms. p. 10) claiming that "regulation theory is broadly faithful to the principles of Marxist political economy" (ms p. 24).
SECTION 3.

“A Critical Approach to the Existing Theories”

We would like to start by defining our approach to the politics of the contemporary capitalist state. This will be done by adding our own critique to the Capital Logic School, as it is very much in line with the critique made by Bonefeld, Clarke and Holloway. In Marx’s terms “All hitherto history is the history of class struggles”. In this sense capitalist accumulation, and its form (ie via an apartheid or an welfare system of reproduction) is a form class struggle can take. But we have to remember that there can not be any struggle with only one contestant79!

Even more importantly we have to see society and history as an undividable whole. History haunts our acts and actions, ideologies of the past influence our beliefs, motives and subsequent actions (in this case we have an influence of the ‘superstructure’ over the ‘basis’ -if we work with terms of the “Eighteenth Brumaire”, which were ultimately developed by the structuralist approach80, and even ideologies and policies developed ‘out’ of our very political system (in the most narrow terms) can have an important impact and influence on political believes and actions81).

As mentioned before it seems to us that the Capital Logic School takes little care of these elements82, so fails to incorporate the main epistemological claim of Marxism ie totality.

Such an approach to (and critique of) the Capital Logic and the German Derivation leads to the conclusion that the ‘Capital Logic’ and the ‘German Derivation are not Marxist schools in their very epistemological premises and postulations; whereas they remain Marxist in their methodological ones as they approach problems of accumulation of capital, reproduction of the labour power, exploitation etc in a materialist way.

Last but not least, there is great danger of determinism in the Capital Logic and the German Derivation schools. By excluding the potential and strength of class struggle (class struggle can have results both within the capitalist system and in the process of its negation and overcoming - ‘aufhebung’-), it as though one views the aggregate society as string puppets

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79 See our reference to class struggles earlier in this chapter.
80 Ultimately analysed by L. Althusser in his ‘Ideology and Ideological State Apparatus’.
81 See for instance the development of the green movement first in FRG and then in the UK or -an even better example as a variety of reasons lack- the impact and will for adoption of Thatcherite policies in Greece. Another case more related to our thesis is the reasons P. Addison gives for the creation of the welfare state in post war Britain. See in the first Chapter of the Thesis about these arguments.
82 At least as it appears in the literature translated in English (Holloway, Picciotto 1978), various articles by J. Hirsch and presented by D. Karagiorgas in Greek (‘ΔΗΜΟΣΙΑ ΟΙΚΟΝΟΜΙΚΗ’, ΠΕΠΟΦΗΣ editions Athens circa 1979).
in the hands of the capitalist class, which exercises absolute control over (and in the) state\textsuperscript{43}. As Miliband sets it in his ‘State Power and Class Interests’ (NLR 138, March April 1983) there are external and internal (viz class struggle) influences and constraints in state decision making.

“The degree of autonomy which the state\textsuperscript{44} enjoys for most purposes in relation to social forces in capitalist society depends, above all, on the extent to which class struggle and pressure from below challenges the hegemony of the class, which is dominant in such a society” (Miliband 1983, p. 61).

Thus, according to Miliband, the state will be less ‘autonomous’, due to the constraints imposed by class struggle. Ginsburg has a similar opinion:

“hence the capitalist state is neither a relatively autonomous political institution, as bourgeois ideology suggests, nor it is merely the economic resultant of the actions of individual or many capitals. The capitalist state produces and reproduces the conditions for capitalist accumulation to occur, and at different periods, and in different economic and political contexts, there emerge quite different kinds of state activity” due to the strength of class struggles (Ginsburg 1979, p. 28).

Gough, referring to the same question holds a similar view claiming that the state ‘requires’ autonomy from the dominant class in order to represent their interests (Gough 1979, p. 41), due to the possible fragmentation of the interests among different divisions in one class. At this point we have to refer to our earlier argument about the contradiction of the capitalist state and we would like to claim that the state cannot represent, implement and fulfil the interests of the bourgeoisie because these interests are contradictory.

As we suggest in our approach to the issue of reproduction and the policies to achieve it, reproduction is an internal necessity for the capitalist economy. Concluding this discussion on reproduction we suggest that, from our point of view and as far as post war Britain\textsuperscript{45} is concerned: Reproduction is the state function which secures the maintenance and reproduction of the productive capacity of the workforce needed for capitalist production, through policies assisting the members of the

\textsuperscript{43} Another problem of the German Derivation Scholl (and indeed of most contemporary Marxist approaches to the state is the entire absence of empirical research and backing, -or disproving- of the theoretical arguments, and the great abstraction in the approach to the ‘state’ instead of the use of case studies. Holloway in his ‘Red Rose of Nissan’ attempts a case study approach, but he falls short of being successful in his analysis. We deal with this question in the next section of this chapter, and in the concluding chapter of the Thesis in Part III, where we make our critique to Holloway more explicit.

\textsuperscript{44} While Miliband by ‘state’ means (and mentions the confusion with) state executive. See Marx, Engels Collected Works Vol. 6 p. 486, as well. Miliband bases his definition on the Communist Manifesto.

\textsuperscript{45} And other states of industrial capitalism as well.
working class in maintaining and restoring their health, faculties, abilities and productive potential in such a way that it will not be destructive for capitalist accumulation or/and state stability. In other words, reproduction in the United Kingdom has taken the form of an assisting state apparatus offering safety, health, employment\(^6\), education, ‘happiness’ and well being to the unprivileged working classes to the financial cost of the better off. A very important point is that this financial cost was not an actual economic one as the productive capacity and obedience of the workforce were secured via these policies, as our reference to C. Offe indicates.

The policies of achieving it, though, are not conducted only by the capitalist class. There are certain clashes in every political system that contribute to the decision about which policies are to be adopted.

**In this sense the state is an outcome of the needs of accumulation and class struggle on the one hand, and the place of struggle on the other.** There can not be state without class struggle and class struggle without state.

However, our approach gives ground for a critique of Bonefeld, Clarke and Holloway as well, by an argument rather similar to that of the critique to the Capital Logic school. All Bonefeld, Clarke and Holloway give class struggles a predominant position in the formation of politics and policies and indeed in their own theoretical understanding of capitalism and the capitalist state. They fail to see that the needs of capitalist economy and accumulation are as important as class struggle. Moreover, they do not examine (as ‘traditional’ capital logic does not either\(^7\)) the very contradictions of capitalist economy, which are the contradictions between the extraction of surplus value and the securing of the perpetuation of this extraction as we mentioned earlier. Thus they (as the Capital Logic school does) only see one side of the capitalist economy this time the side being that of class struggle. As they do not examine the capitalist society in its aggregate form (or at least they underestimate the importance of the other components of politics), they fail to see it in a Marxist way, combining needs, necessities, contradictions of these needs and necessities and class struggles in one unity. From our point of view, there is no need to look for the predominant factor in the development of capitalist economy and the capitalist state as all three factors are interrelated and interwoven on the one hand, and separate and distinct aspects of the capitalist system on the other. Capitalism creates class struggles on the one hand, while it is self-contradictory (in Offe’s terms) on the other.

**So, we would like to indicate our understanding of the state and of the welfare policies in particular as the outcome of both the capitalist needs for**

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\(^6\) Especially in the mid sixties; see next chapter.

\(^7\) This is why we add Offe to the argument.
continuation of production and class struggles within society, and their contradictions, on the one hand and their battleground on the other.

Another important issue in our critique of both the Capital Logic School (expanded so to accommodate Regulation Approach, Reformulation and Offe), and of the counter arguments offered by Bonefeld, Clarke and Holloway, is the complete absence of concrete applied research. State, politics and policies are approached in a great form of abstraction as if they were not elements of human life and action but just words in the pages of academic books.

It could be additionally argued that the concepts of fordism and post fordism -which are widely used both in this Thesis and by other commentators on British politics- are very general and descriptive and thus inadequate as theoretical 'tools'. They show sides of the issue (mainly describe the process of production) and do not allow us to approach the relation between the state and Economy. What is needed now then, is a new approach to the issue/question which will not have these problems. We need a new Political Theory to understand the relation between the state and the economy. One way to achieve this is by the analysis of certain policies such as the policies for the restoration of the productive capacity of the workforce. We claimed earlier that capitalism cannot live without its workforce. But the policies to reproduce this workforce will indicate the relation between state and economy, viz. between state and i) the mode, process and norm of production, and ii) between the state and the forces of production, which depends on iii) the relation between the forces of production themselves, ie class struggle.

This Thesis would like to claim that we cannot understand the state unless we approach some of its actions, activities and policies. Moreover, in order to approach and analyse these policies we want to suggest that it is necessary to undertake some form of empirical research, on concrete and applied policies and their results and repercussions.

The objective is to relate political theory to political analysis. This thesis has theoretical presuppositions and postulations based on abstraction, but no prejudice in approaching the 'empirical world'. Our intention is to apply the political-theoretical framework to the existing policies and try to reinforce, amend or even altogether drop our framework, and adopt a new more operational one. According to our methodological standpoint, Political Theory and theory of political economy cannot stand aloof in the world. They are an outcome of our (humans) critical evaluation of the relation between state and economy, and have to be critically examined.

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88 With the notable exception of Holloway's 'The Red Rose of Nissan', which includes certain references to contemporary developments in industrial relations in a form similar to a case study. For a more detail critique of 'The Red Rose' see Part III, Chapter 1 ‘Conclusions'.

89 Cf. our references to Clarke and Psychopedis earlier in this chapter.

90 Here (and hereafter in this thesis) in the sense of state theory.
We believe that Political Theory is the outcome/theorisation of political research, the theorisation about the relation between the State and Political Economy\(^9\), and concludes on our understanding of the state\(^2\). So, we would like to claim that the starting point has to be the analysis of some specific policies\(^3\) which can be approached in the form of empirical data and reproduced in such a way as to assist us in our project of searching for the actual relation between state and economy and for the actual conception of state ie Political Theory.

Ultimately, social sciences have to divorce empirical research from both behaviourism and empiricism and reintroduce it to a critical approach towards both our theoretical presuppositions and preconditions. From our point, of view there cannot be social sciences without empirical research, only as abstract theories, divorced from the existing world. On the other hand, research should not be restricted only to the collection or to the evaluation of data, but offer a theorisation out of these empirical data. So empirical research is a ‘sine qua non’ for social sciences but falls far from being the ultimate pursuit of them.

We do not agree with the claim that the empirical data will obscure our evaluation of abstract theorisations of the state, and so lead to a wrong or misleading understanding of our subject. The key issue is to examine the relation between state and political economy. In order to create a theory about how these policies are created, we should approach aspects of the policies themselves, and try to relate them to our theoretical framework (and vice-versa).

Additionally, we have to approach, understand and analyse the intention or the assumed intention of the political actor in order to evaluate the policies adopted. This is our motive in approaching in the next chapters the actions themselves and the ideology, motives and motivations behind these actions, as we did on the previous one. Moreover all the ideology, motives, motivation plus actions have to be approached in a combined and aggregate form and way. A critical (Marxist (?) ) approach of these “facts” will show which is the relation between state and political economy. This data\(^4\) performs an ‘on paper’ reflection of trends within society. The social and political facts they are trying to report exist outside and without ourselves. They are not necessarily ‘objective’ or ‘by all understood conceived as such (or as they are)’ but they definitely are opposite standing (or ‘objects’).

The way they are recorded (in a form of statistical data) or ‘reflected’ on paper obviously

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\(^9\) Viz. the relations of production, the distribution of wealth and the reproduction of these relations.

\(^2\) In order to understand what the state is, we have to approach its relation to political economy and how the certain policies occur (ie what Politics is)

\(^3\) As mentioned before, Ginsburg 1979 “Class Capital and Social Policy” follows this line using housing as a case study. See footnote 54 for more details.

\(^4\) The data about subscription to the PHIC in particular.
depends on the way the paper itself is shaped. This is why the ‘cross examination’ of the data and the critical approach to them is needed\textsuperscript{99}.

In other words we will apply our (pre) existing Political Theory, discussed in this chapter, to the ‘opposite standing’ (and potentially objective) political facts, issues and developments in the rest of this Thesis, and try to (re) evaluate it. We believe that Political Theory has to be in continuous ‘dialectics’ with policies and politics, self-cr\-itical and capable of incorporating new theorisations and to amend itself. As put by Th. Adorno, “the categorical difference between the discipline is confirmed by the fact what should be fundamental, namely the combination of empirical investigations with theoretically central questions, has -despite isolated attempts- not yet been achieved” (Th. Adorno 1976, p. 83). We believe that a case study approach to certain policies, can work as the bridge between theoretical and empirical research. From our point of view it is essential to develop a study of the concrete, in order to understand the political changes and developments. The Miliband-Poulanzas debate between the late sixties and the mid-seventies provides arguments both in favour (Miliband) and against (Poulanzas) empirical research in a Marxist framework. We are in agreement with Miliband believing in the necessity of the empirical proving (or just backing) or disproving of our theoretical presuppositions. Empirical research has to approach the concrete standing on a suitable theoretical framework (Miliband NLR, 59, January, February 1970). From our point of view, if theory is not supported by evidence, it stands on a rather fragile basis. The closing of the gap between theoretical understanding of the phenomenon of the state, and empirical research has to be abridged as Adorno mentions. We believe that the case study of the concrete\textsuperscript{96}, can be a step in this direction. So, this thesis will try to be another -isolated (?)- attempt to bridge the gap between empirical research and theoretical questions. As Adorno mentioned “empirical social research is not only a corrective in that it prevents blindly superimposed constructions, but also in the relationship between appearance and essence”

\textsuperscript{99} The theoretical framework of this Thesis is based on assumptions of the Capital Logic School, and German Derivation School in particular and the critique to these schools raised by Bonefeld, Clarke and Holloway. This approach to politics though, was formed in the mid seventies when the KWS was the dominant policy in most European states. But there have been important changes in the management of the economy eversince. The dominant policies now are more monetarist, controlling the supply of money to the economy, and more market oriented than centrally controlled, though in other respects state activity centralisation has increased. The second issue arising from such an observation is how to apply a theoretical framework to day to day politics, when this framework has developed out of a different experience. However, the answer to this is that there is significant continuation of data and of the way this data is presented throughout the postwar period, so we believe that there is both continuity and compatibility.

\textsuperscript{96} In our case the study of the British Mode of Health Maintenance and National Health Service.
(ibid. p.84)”. K. Marx, when writing the Capital, used empirical data (personal observation, newspaper articles, parochial reports, parliamentary reports etc.) in order to examine the level of exploitation and the issue of the working day (cf. Capital Volume I Chapter 10)\textsuperscript{98}. Earlier on, a similar work was done by F. Engels in his “Condition of the Working Class in England”. The main question is how the data should be approached. As previously claimed, knowledge about society and politics cannot exist without any reference to concrete events in society and politics.

In the opposite case, the theories become vague and hollow, standing rather on their head than their feet. This Thesis wants to suggest that social scientists should theorise from the existing data and not leave theories and hypotheses empty of empirical verification. At last we have to reevaluate our theories by comparing them with raw\textsuperscript{99} data about society and trends and tendencies within society.

Since Political Theory is (or at least should be) the theorisation of the political world, we have to approach the existing policies trends legislation etc. As it is beyond the ability, subject and project of the Thesis to conduct original research in the form of questionnaires or widespread personal interviews, we will rely on already collected data on the issues. However, this provides us with the problem that our questions have to be formed according to the existing data (collected by other people for different, or more general, reasons). There is not any data with regard to absence due to ‘unrepaired’ ill health. The existing data mention either days of restricted activity -GHS- or days of absence -SSS-.\textsuperscript{100}

There is not any ‘matching’ of this data by any other previous researcher. This does not mean that our analysis will be restricted by this lack of suitable data for our particular project, but we are not totally ‘independent’ either. As with Political Theory and political analysis, there has to be a ‘dialectical’ relation between the researcher and his object, otherwise we will either fall to methodological determinism (not being able to evaluate the ever existing data for ourselves), or to idealism (that our presuppositions, theories and research projects are immune from difficulties we might face in the approach of the concrete itself).

\textsuperscript{98} While, in the Greek edition of the book, T. Adorno claimed that it is impossible for a social scientist to neglect the methods of empirical research as these methods are ways and means but not ends of research. There are two dangers according to Adorno that should be both avoided. The one is some empiricism without any theoretical framework and the other one is the pseudo-theoretical approaches which tries to cover postulations that are not clearly worked out with some ever existing empirical data. (cf. T. Adorno Η Κοινωνιολογία μεταξύ θεωρίας και εμπειρίας, Παπαδοπούλου editions Athens undated)

\textsuperscript{99} It is not certain that the data will be unbiased. This is why we do not use the term ‘clear’ data, but ‘raw’ data. Furthermore, we hope that the way we use the data in the Thesis will minimise the effect of their bias.

\textsuperscript{100} For a more detailed analysis of the data used, see Chapter 3 of this Part.
SECTION 4:  
“Conclusions and Questions”.  
This Chapter has claimed that there is an intrinsic need for reproduction of the workforce in the capitalist mode of production. It has also claimed that in the Fordist norm of production the state has to undertake certain functions in order to assist reproduction, and that this need forms a contradiction for capitalism, the contradiction in Marxist terms being between the extraction of surplus value and the securing of the condition for this extraction. Additionally, we mentioned that the contribution of class struggles to the formation of policies and politics should not be neglected; however, we do not give to any factor (needs, contradictions, or class struggles) any ‘leading’ or ‘predominant’ role over the formation of policy. Such an understanding of politics (especially the ‘functionalist’ Capital Logic part of it), which was developed during the years of Keynesian Welfare State, is confronted by a number of analytical problems and questions which arose after the changes imposed in spending after 1979.  
These questions are:

Are the cuts and changes in the KWS spending and structure going to create problems for capitalism due to inadequate reproduction? In other words, what is the validity and relevance of the Capital Logic theories in (with) contemporary political developments?

Is it that the changes in the way reproduction is achieved indicates a transition towards a ‘post-Fordist’ form of state, with a two-tier system of ‘reproduction procedures’?

What is the contribution of class struggles in the formation of policies?

In order to answer these questions we will undertake a detailed case study analysis of the way the British state has chosen to keep its workforce healthy (viz. one of the aspects of maintaining the productive capacity of it). We call this set of policies Mode of Health Maintenance (MHM), and we will examine how effective it has been over the years in keeping low absenteeism from the workplace, due to health reasons, and in the quest of a transition towards a ‘post-Fordist’ society we examine whether the Health Care Provision Provident Associations (which we call Private Health Insurance Companies -PHIC-) contribute to the provision of a two-tier health care system compatible with the descriptions of a ‘post-Fordist’ society. These issues are going to be discussed in more detail in the last

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101 Choosing dates is always arbitrary. There is some dispute about the ‘right reference year’ for the cuts in the KWS. A number of commentators suggest 1976 after the IMF intervention. Clarke suggests 1976 but before the IMF intervention, while the ‘anti-Thatcher’ ones use 1979. As the exact ‘reference year’ is of little importance to our analysis, we will use 1979 conventionally, while we mention 1976 when more appropriate.

102 These questions will be approached in more detail in the third chapter of this first Part.

103 BUPA, PPP and WPA For justification of the use of the term see the relevant chapter in Part II.
chapter of this Part, together with an approach to our data sources.
The next Chapter is going to examine the construction and the reconstruction of the Keynesian welfare state in post-war Britain, with particular reference to the ‘Thatcher years’. Chapter 2 will serve as a first application of our theoretical framework, to a lesser extent, and mainly as background information for the rest of the Thesis.
CHAPTER 2
AN OVERVIEW OF POLITICS AND
POLICIES IN THE UNITED
KINGDOM 1940-48 AND 79-89.

INTRODUCTION.
In this chapter we will give a short reference to the history of the construction and
reconstruction of the British welfare state, in the context of developments in British
politics, between the 1940s and the 1980s. The Chapter has a dual objective: Firstly to
approach the general political environment in which the policy changes (which we will
examine in the second Part of the Thesis) took place, and secondly enter upon the
examination of our theoretical framework. We make this general approach, because we
understand the whole Keynesian Welfare State (hereafter KWS), not only the National
Health Service (hereafter NHS), as the way labour power was reproduced in Britain during
the post war period.
The Chapter is divided into two main sections: The first deals with the period of
construction of the Keynesian Welfare State and the NHS, and the relevant developments
in British politics during that period; the second section observes the reconstruction of the
KWS and the relevant changes in state policies especially in taxation and expenditure.
Each section is further subdivided into a number of paragraphs examining the ideological
components of the periods; the level of class struggles during those periods; and the applied

ded
policies and policy changes. In its general definition ideology is a set of ideas and beliefs that aims to motivate or to justify changes or (conformity!) in politics and political action. In this chapter we will use the term ideology in a rather narrow form meaning the beliefs, ideas and rhetoric prevailing in each period. We have limited ourselves in this narrow meaning of the term because we wish to concentrate on the changes in the beliefs and approaches of the governing party (we use this expression, despite the awareness of different ideologies within parties).

The chapter stands on a variety of both primary and secondary sources. There has been extensive approach to National Accounts and Acts of Parliament (especially in section two), whilst commentaries on British post war political history have also been consulted.

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4 While in section one the analysis of class struggles follows the approach to ideology and leads to the construction of the welfare state, in section two the analysis of class struggles follows the approach to ideology and policy changes. This is because we want to indicate that the limits to policy changes are not imposed by the inadequacy of ideology, but by class struggle.

5 We are aware of the potential unclarity of our approach. From our point of view, ideology is not a set of ideas or beliefs that exists by itself and is somehow 'out' of this world. For Marx and Engels the ideas people have about the world are the outcome of their relation with nature, other humans and their material life process (See “The German Ideology”, MECW vol. 5 pp. 36f). These ideas are “phantoms” in the brains and “it is not consciousness that determines life, but life that determines consciousness” (oc. 37). Ideology is not something out of and irrelevant to society and to societal clashes and struggles. In the “Eighteenth Brumaire of Louis Bonaparte” (MECW vol. 11) Marx has shown that each class has its own ideology according to their relation to the relation and process of production and that “upon the different forms of property, upon the different conditions of existence, rises an entire superstructure of different distinctly formed sentiments, illusions, modes of thought, and views of life. The entire class creates and forms them out of its material foundations and out of the corresponding social relations” (oc. 128). So, ideology is our conception about our relation to the world and to the process of production. Our conception about our relation to the world however, can not be always clear and immaculate. This is defined as false consciousness.

6 This narrow understanding of ideology could be called the ‘dominant ideology’, since “the ideas of the ruling class are in every epoch the ruling ideas; i.e. the class which is the ruling material force of society is at the same time its ruling intellectual force”, since the dominance over the material means of production also leads to the dominance over the mental ones. “The ruling ideas are nothing more than the ideal expression of the dominant material relations” (MECW vol. 5. p.59 underlining in original). Therefore ideology has to be seen as an attempt to achieve legitimacy as well, or in Gramsci’s terms to create the ‘social cement’. From our point of view ideology has in addition to be seen as the creator of change. It is what liberals call an innovator, or some structuralist theorists might call ‘influence of one part of the superstructure over the other (ideological over the legal) and finally-subsequently- to some changes into the basis’. From our point of view these changes are a part and parcel of the whole societal shifts. Their understanding as cause or effect of the rest of the changes depends on the subjective viewpoint of the participator, supporter or opposer of the certain ideology.
SECTION 1:

"The Construction of the Welfare State in Post War Britain".

As explained in the introduction this section deals with three main issues. Firstly, we will examine the theoretical and ideological components of the interventionist and welfare approach; i.e. the "General Theory of Employment Interest and Money" of John Maynard Keynes, and the ideology of the creators (we will briefly refer to the "Beveridge Report" and other works of this period). The second issue concerns the politics which lead to the adoption of the policies of the welfare state, in other words the militancy of the left and the Unions, and harmful by-elections for the Conservative Party. And finally, the history of the creation of the KWS and of the NHS in particular.

The theoretical and ideological components.

"Keynesianism" (as a term) indicates a set of economic and financial policies, according to which the state tries to maintain high levels of employment through 'active demand management' and intervention in the economy. The first detailed analysis of these policies was offered by Keynes in his 'General Theory', which was first published in 1936, some years after the Depression of the 1929 world crisis. It was a period during which orthodox economics had shown their limits in the most tragic and profound way. Attempts for central control over the economy had started earlier (see for instance the 'New Deal'), but Keynes was the first to theorise the entire process and to offer a coherent theory of state intervention to the economy. Keynesianism as an economic policy characterised British politics from 1942 (the first Keynesian budget -see next paragraph-) up to the mid or even late seventies. This justifies a quick overview of the theory, which in rhetoric at least, has been abandoned by the current British government.

As previously mentioned, Keynes's contribution was mainly on the question of control of unemployment. He regarded unemployment as

"the outstanding faults of economy and society in which we now live (....) its failure to provide full employment and its arbitrary and inadequate distribution of wealth and incomes." (Keynes 1936, p. 372).

Beginning the evaluation of his contribution we have to approach at first the concept of unemployment as given in this work. For Keynes,

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7 P. Mattick suggests that the Keynesian theory has no actual relation with the policies of the New Deal. Though Mattick agreed that the New Deal was an attempt to overcome problems of capitalism by central state intervention, he holds the opinion that the policies of central control and of the multiplier are as old if not older than capitalism itself. Equally he notes that Th. Roosevelt was against any idea of dole for the unemployed, something that is central to Keynesianism. (See P. Mattick "Economics, Politics and the Age of Inflation" pp. 114 ff.)
"Men are involuntarily unemployed if, in the event of a small rise of the wage-goods relatively to money wage, both the aggregate supply of labour willing to work for the current money wage and the aggregate demand for it at the wage would be greater from existing volume of employment." (Keynes o.c. p.15 emphasis in the original).

The volume of employment depends on the aggregate supply function, the propensity to consume and the volume of investment, while the other independent variables are, the variable efficiency of capital and the rate of interest (ibid. pp. 29 and 245). Employment will increase (ceteris paribus) as a result of investment (p.98). One of the main questions regarding employment and investment is ‘On which sector of the economy is this investment going to be directed’. There is a qualitative concern, as this investment has to be on new jobs and not on enterprises in the third sector of the economy or financial ones (see p. 220 also). But let us return to the relation between consumption and the level of employment. An increment of income will result through the function of the multiplier to the increase of the number of people employed in a certain proportion of the initial increase (oc. 116-117). For Keynes it is better to employ people to get bottles full of money from closed pits than not to employ them at all (129); it is from this quotation that Beveridge derives his view of employing people to dig holes in the ground only to fill them up again. For Keynes the importance of the state is crucial. It is the state’s responsibility to balance between economic growth and the welfare of the people. The growth of capital equipment “shall be at the rate which does not put disproportionate burden on the standard of life of the present generation” (ibid. 220). Keynesian theory considers “the vital importance of establishing central controls in matters which are now [1936] left in the main to individual initiative, there are [though] wide fields of activity which are unaffected. The State will have to exercise a guiding influence on the propensity to consume partly through its scheme of taxation, partly by fixing the rate of interest, and partly perhaps in other ways. Furthermore it seems unlikely that the influence of banking policy will be sufficient by itself to determine an optimum rate of investment.” (ibid.377).

Keynes offered a theory considering both the need of state intervention for the control of unemployment, and the maintenance of a standard of living. But the problems of implementing such a theory to policy were not only economic or financial. On the political level when Beveridge tried to introduce these ideas in applied and certain policies, the then Chancellor of the Exchequer declared that this plan was “an impracticable financial commitment” (Addison 1975, p. 220). A coherent economic strategy, and existence of poverty and maldistribution of wealth in the pre-war British society are not adequate to explain the emergence of the Keynesian Welfare State. There must be a certain political will which would support these suggestions and, of course, would clash with the other social interests which do not want such a change in policies. After this short reference to the
‘theoretical’ or ‘political economy’ aspect of the creation of the welfare state in Britain, in the next few pages we will examine the ideology that assisted to the formation of the welfare state in post-war Britain.

The very first steps indicating a desire to create a welfare state in Britain were introduced by the 1911 Liberal government and a stronger will had been expressed in 1908 by W. Churchill (then Liberal President of the Board of Trade), who took up the Fabian slogan (introduced by Sidney and Beatrice Webb in 1903) of the ‘legally enforced national minimum’. Again in 1937, he insisted on the need for an egalitarian health system for Britain, since high costs were delaying treatment (P. Addison 1982 p. 211 and D. Widgery 1979 pp. 16-17 and 26). The London Times editorial (1 July 1940) expanded the notion of democracy incorporating not only the “traditional” right to vote but the right to live and have a job. This editorial had an intensely egalitarian demand asking for a new European house: “The new order cannot be based on the preservation of privileges whether the privilege be that of a country, or a class or of an individual.” (ibid.).

About two and a half years later (20 November 1942), Sir William Beveridge published his “Report” focusing on the efforts of reconstruction on the attack on the ‘five giants’ namely Want, Disease, Ignorance, Squalor and Idleness (para. 8). These ‘giants’ should be driven from post-war British society at any cost, in order to create the ‘new house’. It was a case of establishing a new ‘national minimum’ which should leave place for individual activity as well. This new national minimum differed from the previous Lloyd George’s one because of its egalitarian claim (ibid. para. 9 and para. 66).

As mentioned earlier, it was feared that this ‘new house’ could cause economic problems (not only in terms of stealing wealth from the well off to redistribute), but even in terms of fiscal figures. Beveridge’s strong answer was that if they let unemployment rise, and let disease, hunger, and squalor exist just because of fear of internal national debt they would “lose all sense of relative values” (Sir W. Beveridge 1944 para. 198). Such a loss of values can also be expressed in a totally different way. Higher spending may go on unnecessary luxuries instead of basic human needs. There is a need of state intervention in order to ensure that the extra money will be spent properly for better housing, sanitation and nutrition (ibid para. 259).

Human happiness for Beveridge does not mean ability to consume, ie. money possession. Real happiness can be caused only by active employment which is considered to be participation in social life, so (for Beveridge) the state was obliged to provide employment to its citizens (‘Report’ para. 440). In our view this is his understanding of the ‘General Theory’ of Keynes (to which we have already referred) since he mentions

“that it is better [for the State] to employ people on digging holes and filling them up again
than not to employ them at all; those who are taken into useless employment will, by what they earn and spend, give useful employment to others. It is better to employ people however the money for paying their wages is obtained than not to employ them at all; enforced idleness is a waste of real resources and a waste of lives, which can never be made good, and which can not be defended on any financial ground. The object of all human activity is not employment but welfare, to raise the material standard of living and make opportunities for wider spiritual life”, (Sir William Beveridge 1944 para. 198).

Beveridge’s will to create a welfare state in post war Britain was formidable. He claimed that his proposals could work under socialism, capitalism or an alternative social system alike (1944 para. 300), though later on in his postscript does not feel bound on private ownership of the means of production and insists that the proposal has to be treated according to its results and not according to confidence in businessmen (ibid Postscript page 273).

This quotation can indicate the reason why the then government was reluctant about the absolute application of the ‘Beveridgian’ will for welfare. There followed, however, great political shifts and clashes, which forced the government to overcome their reluctance.

Despite the emergence of the ‘fully developed’ welfare state after the Second World War, a shift in policies can be traced to the prewar period. Highlights of its policies were the reluctant welfare systems and the first piecemeal policies which were introduced due to the poor health of the Boer war conscripts, the high rates of perinatal and infant mortality etc (Ginsburg 1979, p. 32). In the area of confrontational politics some events even before the First World War such as ‘poplarism’ (the resistance of the local councils against national cuts of 1910-13) had as a result, the equalisation of the rate burden and the increase of the unemployment benefits. And so the poor the unemployed and the sick came out of the shadows, in new political action (but the then existing government was not ready to compensate to these demands) (David Widgery 1979 pp 19-20). Other evidence of its earlier development include: the real universal suffrage; the interim report; the shift of the health care from the ‘Poor Laws’ to the general health services of the country under the Lloyd George coalition government and the welfare demands of the Labour Party of 1918 (ibid. p. 22); and the 1926 General Strike which Labour did not support in order not to create rival leaders who would obstruct ‘the civilised way’ of resolving problems in Westminster (Addison 1982 p. 164).

Three years after the strike and for the whole of the next decade (1929-38), the miners’

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8 See the case of relative values mentioned in this chapter once again.
9 Contrary, Ginsburg mentions that “the first major post-(First World) War confrontation occurred in Poplar is 1921 over the refusal of the Labour guardians to levy rates on behalf of other bodies....(it) was a protest against the unequal burden of poor relief expenditure and local rate income .......(and) a demand increased subsidisation of the poor boroughs” which ended up in victory for the guardians who were initially jailed. (p.59).
militancy was extremely high and "there were about 2 million working hours per year lost because of strikes" (Correlli Barnett 1986 p. 86). There was rapid growth of the power and membership of the Trade Unions in the 1936-48 period. Even more the T.U.C. was very strong and influential in the Labour Party in the 1931-37 period, which were actual dictating to the L.P. what policies to choose in the annual conference (Barratt Brown 1972 p. 151 and Addison oc. p. 47).

The 'civilised way' of Westminster can be expressed in the terms of the 'middle way' as well, which was a reform within capitalism. Over that period the claim for the abolition of capitalism altogether, though ideologically strong in the Labour Party, had no real political power. The fate of the pioneers of the middle way in the thirties (Lloyd George and Keynes) was to be ineffective as they did not seek to belong to either of the two major parties and (at the same moment) to (belong) to both of them, but in the late thirties the Centre was becoming better organised (Addison oc. p. 35). In the inter-war period the Conservative government established state control over broadcasting, generation of electricity and overseas airways, and increased state intervention in economic activities (ibid 31). There was a failure of orthodox economics to secure full employment (ibid and Beveridge 1942 para 296). The great mobilisation of the population during the Second World War (to be referred to as 'war' in the rest of this chapter), and key figures in the Labour Party held deep fears and hopes for post war society; war was considered as the midwife towards a new Britain (Addison oc. 119). At this point we can recall the London Times editorial of 1/7/40 indicating the growing concern and will about new policies. We can claim even a historical sequence of these events as the 'Beveridge Report' was published just three weeks after the victory at El Alamein, one of the turning points of the whole war (ibid. p. 17).

But the sequence is not just a chronological one. There is a strong political relation, which can be put in a rational political analysis explanation. The main reason for the application of the 'Report' in real politics is to be found in the British political events of that period. The electorate's swing to the left (some small but highly indicating number of votes between 1940 and 42) can be explained by the leftish propaganda of the Labour Party (Tory explanation/complaint) or by the levelling of classes caused by the wartime devastation and bombing. Other factors include the Russian success in the war fronts, the faults and accusations about problems in the process of production and the memories of the post First World War conditions and the fear of their recurrence (Addison's explanation). It can also be seen in the serious defeats of the Tories at some by-elections (as

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16 This growth continued up to 1953. Some decline, especially in the property of the Trade Unions, commences after 1956.

11 And another which is related to the post war economic structure and functions; we will examine this in the next chapter of the thesis.
in February 1943); and the growing support for the ‘Report’ and especially, according to the opinion polls, of the ‘jobs for all’ claim. This ‘swing to the left’ though, should not be over-exaggerated as there were certain limits and constraints by the Labour Party itself, and there was some feeling of coordination and partnership between Conservative and Labour for the long term future. So, the war Premier himself in his radio broadcast of March 21 1943 announced his commitment for the reconstruction of post war Britain in terms of abolition of unemployment, and the adoption of Keynesian planning and control of the economy (Barnet, 1986 p. 258 and Addison oc. pp. 127, 143, 163, 164 and 227).

There was strong and growing public support for Beveridgian ideas, Beveridge quoted in his ‘Report’ that:

“For the insured person the answer is clear. The capacity and the desire of the British people to contribute for security are among the most certain and most impressive social facts of today [1942]. They are shown in the phenomenal growth both of industrial assurance and on hospital contributory schemes.” (para 296).

Additionally, there were demands and pressures for a more egalitarian postwar Britain. But there were obstacles and highly influential different opinions as well. The then Chancellor of the Exchequer, Kingsley Wood, warned the Prime Minister as early as the 17 November 1942, about “an impracticable financial commitment”. From his point of view the cost would be intolerable to the tax payer (there was also a danger of re-distribution from the lower to the higher strata), and such a commitment to welfare spending would obstruct spending on other sectors (Memorandum quoted by Addison oc. 220). Other main tasks of the government were to maintain the Empire and the international military and financial role of Britain (Jacques 1983 p. 40). The government adopted the Beveridgian policies despite the Chancellor’s fears. The public, though, remained unimpressed. While greatly approving the acceptance of the ‘Beveridge Social Security Plan’, the main public concern continued to be housing and jobs, with some pessimism about non fulfilment of high hopes for the peace period (ibid 247). The budget which Kingsley Wood himself introduced however (even before his ‘memorandum’) in 7 April 1941 was considered to be a Keynesian triumph, making the budget the key regulator for the British market economy (ibid. 170).

The Attlee governments, having a majority of 150 perpetuated, consolidated and even expanded the welfare state though they were facing great problems in terms

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12 The fears of the Chancellor (K. Wood) are an indication of the contradictions of capitalist production (in Offe’s sense), if the introduction of the welfare state is approached as a policy to alleviate social problems (viz. potential problems for capitalist production) something clear in the Beveridge Report, or to reduce tensions and challenges to capitalism which indicates the importance of class struggles (contradiction in Gough’s terms). See previous Chapter.
of shortage of food, raw materials and fuel, forced by the pressure-support of the left of the Party (ibid 273, Pollard 1983 pp 266 ff., and Fraser oc. 207). These policies succeeded in strengthening national unity.

There was a new equilibrium and balance in post war British politics due to the creation of the welfare state and the support of the policies and desire for its creation. Having dealt with this background we can proceed to the creation of the creation of the Keynesian Welfare State itself.

**The Construction of the Welfare State in Post War Britain.**

a) Construction of the Keynesian Welfare State.

The policies for the creation of the welfare state were not planned in order to bring to life some abstract ideas about how the state should be organised and run, but in order to solve certain problems of the British post war society (Fraser 1973 p. 108). Great Britain was the first state to develop a K.W.S. in the post war period. Having approached the ideological and theoretical components, and the political struggles for its imposition, we will examine how and when these policies developed. The pre-Thatcher era of the K.W.S. can be divided (according to M. Wicks) in three sub-periods:

A) The construction period, dominated by social reform, commencing with the ‘Beveridge Report’ which lasted up to 1951;

B) The period of development and growth of the K.W.S. and the consensus about it, under the Conservative governments between 1951-64; and

C) The period of anxiety and uncertainty from the mid sixties to the late seventies; (M. Wicks 1987 p. 15).

As stated earlier in this paragraph we will focus on the first period of the K.W.S. The construction of the welfare state was not the only policy component of the 1945 Labour government. We have also to mention the policies of nationalisation:

I] In 1946: a) civil aviation, b) cable and wireless, c) the Bank of England, and d) the coal industry;

II] In 1947: a) electricity, and b) railways;

III] In 1948 gas;


Focusing our interest again on the creation of the Welfare State we return once more to the ‘Beveridge Report’, and its eighth and ninth paragraphs, about the

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13 Taxation and expenditure regarding this period appear in the relevant paragraphs of the next section.

14 Jessop suggests that the policies of the construction of the welfare state were completed under the first post war government up to 1948 (see Jessop 1980 p. 28 and 1987 p. 8)
"Attack upon Want. But Want is only one of the five giants on the road of reconstruction and in some ways the easiest to attack. The others are Disease, Ignorance, Squalor and Idleness." This was considered to be a state's responsibility and the need of state contribution to the problems was demanded as well, for "establishing a national minimum" which should leave place for individual activity as well.

New Acts were introduced during the years that followed the "Beveridge Report". We can highlight the housing policies of A. Bevan, the Education and the Family Allowances Acts of 1944 (during the coalition government) and the National Health Service Act of 1946 (M. Wicks oc. p. 17).

These policies existed as 'ideas' in the 'Beveridge Report', suggesting redistribution of income through compulsory insurance and children's allowances; comprehensive health and rehabilitation services and maintenance of employment (para. 14 and D.S. King 1987 p. 51). State contributions family rent payments was also mentioned in the Report (para. 197).

The modern welfare state was fully established in 1951 (or 1948 as previously mentioned). It stood on a system of national insurance which guaranteed a minimum income under cases of unemployment, accident, sickness and old age. This 'national minimum' was financed through individual contributions. There was another 'national minimum' for health, education, housing and child welfare which was financed through taxation. The definition of the terms taxation and contribution is clear in the 'Beveridge Report' (para. 272):

"(...) The distinction between taxation and insurance contribution is that taxation is or should be related to the assumed capacity to pay rather than to the value of what the payer may expect to receive, while insurance contributions are or should be related to the value of the benefits and not the capacity to pay. Within insurance a further distinction may be drawn between voluntary and compulsory insurance." The difference is that in voluntary insurance the contribution varies according to the degree of danger, while in compulsory it does not. "The main issue lies between taxation and insurance contribution. Taxation implied regard to means; as insurance contribution for the same benefit, whether or not it varied with the risk, should not vary with the means of the person who pays it."

In the case of insurance contribution, the poor and the rich citizens are treated alike, while in taxation the rich pay more (because of their ability), for the general purposes of the community (para. 273).

The employer had to contribute in insurance as well, according to degree of danger of his employees; so for financing insurance expenditure there is a tripartite scheme of contribution (National Exchequer, insured citizen and employer) (para. 275 and 277). "The increase of the employers' contribution from £66 million in 1938-39 to £137 million in 1945 corresponds to the proposed increase in their rate of contribution" (282).
Traditionally, social policy has been taken to consist of the main social services: social security, education, health and housing, joined more recently by social work or the ‘personal social services’ (Parry, in Drucker 1986 p. 198). After this short review of the creation of the whole KWS in Britain we now turn to the NHS which is our specific area of interest.

As David Widgery claims highly sophisticated health care is a quite modern innovation. In the mid nineteenth century, Doctors were often better in their Latin than medicine, nurses were ignorant of their job, there was a great lack of equipment, and the main task of a hospital was not to do any more harm to the patients. Even this task was not achieved by all hospitals (D. Widgery 1979 p. 1).

The first steps in the creation of a health service were taken by Lloyd George in his 1911 Act which established free consultation with a general practitioner and free drugs according to the G.P.’s prescription. This Act introduced the employers’ insurance contribution by the ‘Panel’ and the ‘Stamp’ and though it was not radical and seemed more to collaborate with, than to be an alternative to the (then) private health insurance companies, it still faced great opposition from them. “It was a method of replacing the Poor Law with a modest Treasury expenditure” (ibid pp. 16-17).

As Richard Titmuss observed later on, specialisation in the medical profession was one of the main reasons to convert medical care from an individual enterprise to a social service (R. Titmuss 1958 p.135).

In the ‘Beveridge Report’ it is assumed that restoration of health is a duty of the state; as paragraph 427 mentions the state is obliged:

“(...) (a) to provide a medical service directed towards the achievement of positive health, of the prevention of disease, and the relief of sickness;
(b) to render available to every individual all necessary medical services, both general and specialist, and both domiciliary and institutional”.

Aneurin Bevan was the person who applied the Beveridge report to specific and coherent policies. For him poverty should not be a hindrance, or wealth an advantage in the pursuit of health. “He wrote that ‘a free health service is a triumphant example of the superiority of collective action and public initiative applied to a segment of society where commercial principles are seen at their worst’” (D. Widgery 1979 p. 25). As mentioned earlier, high health cost was delaying treatment in 1937 and Winston Churchill had insisted upon an

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15 This ‘descriptive’ definition is in odds with the one given by Muller and Neussus and cited in the previous Chapter, as it includes the issues of ‘preventive welfare’.

16 These Private Health Insurance Companies are not the same we the ones we will examine in Part II of this Thesis. Contemporary PHIC were formed after the war mainly through mergers and amalgamations of the old ones.
egalitarian health system for Britain (ibid p 26). It was understood that the cost would be high and that it could be covered only by the State “this would mean nationalisation of the hospitals” (Bevan reported ibid. p. 30). The National Health Service was created by the 1946 National Health Service Act (Chapter 81 of the Book of Statutes). As far as its structure and organisation is concerned:

“At the head of the Service is the Minister of Health, advised by the Central Health Services Council and a number of Standing Advisory Committees. These are chiefly composed of professional people representatives of various interests, who are appointed by the Minister after consultation with the organisations concerned. In practice the Minister appoints those who are nominated by the professions.”

The Minister has as a duty to provide services for prevention, diagnosis and treatment of illness. (Titmuss oc. p. 136).
On local level the Health Centre should provide:

“General medical services
General dental services
Pharmaceutical services
Specialist and out services for out-patients
Any of the services the Local Health Authority is required to provide Health education.” (Charles Hill and John Woodcock 1949 p. 214).

The whole civilian population’s medical care is to be provided by the general practitioners. Their salaries were to be funded by a central pool in which about £41 million was given. This amount is estimated by multiplying the 95% of the civilian population by 18s. (ibid p. 111)7. No general practitioner should “demand or accept any fee or other remuneration in respect of any medical treatment” (ibid appendix VI p. lxxiv). Apart from free medical care by the general practitioners, all people were entitled to have free sufficient drugs and medicines according to their G.P.’s prescriptions, and there was no limitation to the cost of the drugs necessary for the proper treatment of the patient; additionally, free electric hearing aids were given to deaf people but there was only one type available under the N.H.S. The use of ambulances was to be free of charge for the entire population (ibid pp. 200, 207, 223). The only charges were for accommodation of the patients in single rooms or small wards if they were to specifically request it (ibid. Appendix XI p. xci).
But the development of the National Health Service was not as sufficient and quick as the laws and official papers show. “Not a single hospital was built between 1948 and 1955 and only six were finished in the next ten years” (D. Widgery 1979 p. 49). Ten health centres,

7 A little care is to be paid at this point as the data about finance of the G.P.s are given before decimalisation in 1971.
having clinical standards, opened in 1948, but as late as 1969 there was a total of only 87; moreover, in 1963 most of the hospitals and especially these in workers’ districts were operating in very old buildings (ibid pp 65-66).

Considering the politics of the construction of the National Health Service we will first examine some aspects of its finance.

The NHS was funded mainly by taxation, and the then government were committed to pay the cost however high it could be. The initial investment on the NHS was £257 million in current prices, or £355 million in standard 1958 ones. Such an investment not high as a percentage of the GNP (about 2.47%), but it had an upward trend\(^\text{18}\). As Hill and Woodcock claim, apart of taxation, there was compulsory employee’s and employer’s contribution. The manual workers had to pay 5% of their salaries, while their employers 6% and the ‘others’ 6% of the salary while the employer contributed 8%. (Hill and Woodcock 1949 p. 244).

A. Bevan wrote “No government that attempts to destroy the N.H.S. can hope to command the support of the British people” (quoted by Widgery 1979 p. xv).

The creation of the N.H.S. was seen as the triumph of the socialist and egalitarian ideology, while its cost and the financial burden to the tax payers show the dual function and the contradiction of the welfare state.

\[\begin{align*}
\text{D) Summary and conclusion of section one.} \\
\text{The KWS was introduced to British politics and Keynesian management became a key factor of British politics in the mid forties. British state and British politics undertook an important transformation with the state expanding its activities in the sectors of welfare and recreation on the one hand; and on economic activities (through nationalisation) on the other. These policies were triggered by the level of class struggles and alliances at post war period and manifested (and assisted) by ideological changes, related to traditional liberalism and the influence of the Second World War\(^\text{19}\).}
\end{align*}\]

The period that followed the construction of the welfare state is usually referred to as the years of ‘Butskellite’ consensus. Though Wicks (1987, p.15) makes a distinction between the period of consolidation (1951-64) and the period of anxiety (1964-late seventies), we

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\(^{18}\) The 1948 current prices figure is an estimate. For more details on figures see Part II, Chapter 1.

\(^{19}\) The issue of reproduction of the productive capacity of the working class as a reason for the creation of the welfare state (with which we will deal in the next Chapter and in most of the Thesis thereafter) is based on theoretical analysis of the welfare state by the ‘capital logic’ school, and can not be included in the reasons which ‘triggered’ the creation of the KWS. The only such ‘trigger’ or relation between state action and the health condition of the working class can be found in the worries of the military (and subsequently of the government) about the state of health of the working class soldiers during the Boers’ war.
would not like to elaborate on this issue\(^20\), since the welfare state, and the policies of nationalisation and social democracy were prominent (despite some changes) throughout the period, especially if we consider the sharp contrast with the period that followed. Policies to maintain high employment, high public expenditure in housing, and education (health will be examined in great detail in the next Part), increasing membership of the Trades Unions and social democracy\(^21\) were indicative of the strength of the working class (and its allies) over this period.

\(^{20}\) However, there is going to be some reference to welfare expenditure regarding these in relevant tables of Part II, when dealing with detailed analysis of the NHS.

\(^{21}\) Sometimes referred to as 'beer and sandwiches at number 10'!
SECTION 2:
"Reconstruction of the state and the KWS under the Thatcher Governments."

Apart of the changes in the whole of the Mode of Health Maintenance in general, and the National Health Service in particular, there have been significant number of other changes in British politics between 1979 and 1989, in comparison to the policies implemented during the post 1945 'consensus' period. Despite the need of focusing for research reasons, politics cannot be seen as a 'single' or 'monistic' discipline. A general overview of the aggregate political developments in the past ten years is necessary in order to approach and analyse the reasons, implications and repercussions of the changes in our area of interest. This section attempts to address these issues. The sources are both primary (Financial Statistics and the Statute Books for Acts of Parliament) and secondary (commentaries on policy issues and politics during Thatcherism). The section is divided into three subsections, the first dealing with New Right ideology, the second with the economic and policy changes, and the third with the level of class struggles and class alliances in contemporary Britain. The first subsection is divided into two 'paragraphs', dealing with New Right theorists and ideologists, and New Right and CP politicians respectively. The second subsection with the questions of taxation and spending allocation; and policy changes such as housing policies and the various benefits, education, privatisation, trade unions and industrial relations, central and local government, official secrecy, criminal justice, and policies of monetarism and high Pound Sterling. Lastly we will address the question of 'more or less state' after 1979, and argue that there is neither more, nor less but different state for the past 12 years. Finally, the third subsection will

22 Which will be examined in great detail in Part II.

23 This Chapter will not try to be either a bibliographical guide to the subject of 'Thatcherism', which runs to about 300 titles, or an in depth analysis of the post 1979 British politics. Neither it will form a comprehensive critique of the existing main arguments about Thatcherism (namely the Authoritarian Populism and the Two Nations Approach), though it will refer to them. It will only highlight some of the most important changes of policy during Thatcherism.

24 It should not be assumed however, that the changes start in 1979 coming out of the blue. Changes in the British KWS can be traced as far back as the mid sixties with the abandoning of the commitment to full employment and the relevant policies and the adopting of policies of 'redeployment' (the pursuit of 'rationalisation' by the introduction of redundancy payments in order to reduce the workforce in basic industries -see Gough 1979, p. 53) under the then Labour Party government. In addition cuts in expenditure were attempted in mid seventies by the Heath governments, which tried (and failed) to transform industrial and Trade Union -government relations as well. Last but not least, the first important cuts were adopted by the Wilson and Callaghan governments, especially after the 1976 fiscal and financial crisis and the adoption of the IMF loan and intervention. These cuts affected mainly housing and education.

25 See Gamble 1988 p. 28, as well.
examine the class struggles\textsuperscript{26} of the period as a limiting factor to the total imposition of the New Right ideology to applied policies in contemporary Britain.

a) New Right Ideology.
The approach is going to be at two levels, firstly dealing with the ‘theorists’ and secondly with the ‘politicians’, and finally some personal comment.
For the New Right, ‘liberty’ as a value is supreme to any other and the source of all other values in human life. Its utility is that it offers the best opportunities to the individual in society (F. Hayek, 1960, p. 6). This freedom is both economic and political, and political freedom is this cause of the economic one. As King (1987, p. 28) observes, political freedom remains unfulfilled if not accompanied by economic one. For the libertarians liberty has a negative concept as the absence of coercion\textsuperscript{27} and according to Hayek (o.c. p.85)

"the great aim for liberty has been equality before the law" but liberty has “nothing to do with any other sort of equality, but it is bound to produce inequality in many respects” (ibid.).

But as previously mentioned liberty is the supreme concept, aim and condition, so the idea of an egalitarian society seems to suit more some ‘primitive’ [sic] societies (o.c. 49).

“The fact that certain advantages rest on human arrangements does not necessarily mean that we would provide the same advantages for all, or that if they are given to some, somebody else is thereby deprived of them” (o.c.89).

King (o.c. pp. 38-43) rightly remarks that for the New right theorists (and especially for Friedman and Hayek) the ideas of social equality and social justice are incompatible with the idea of freedom since in order to achieve equality and justice the government has to introduce policies that will be diminishing the spectrum of freedom of choice and action, ie. coerce. For the very same reason liberty is more important than safety because the preservation of freedom requires great sacrifices; and Hayek (1976, p. 99) concludes (quoting Benjamin Franklin) that “Those who would give up essential liberty to purchase a

\textsuperscript{26} By class struggles we mean both the resistance of the working class to the imposition of the will of the bourgeoisie and the effort of the bourgeoisie to impose their will. Moreover we take into account the actions of the ‘other classes’, as far as distribution of product and security of property are concerned. See Chapter 1 on theoretical definitions for more details.

\textsuperscript{27} We will deal with this matter in more detail in the course of this chapter.
little temporary safety deserve neither liberty nor safety." Following this approach it is easy to understand the libertarian theorists distaste for planning. They claim there might be agreement on planning but not on the direction of the plans themselves, so these plans might prove contrary to the desires of people who have originally agreed and given their consent to planning. So planning can lead to totalitarian regimes (Hayek 1976, pp. 45-53).

Having seen all this opposition of the New Right to equality, planning and so forth we can return to our initial point that for the New Right theorists liberty is a negative concept. Buchanan (1975 p.92) claims that "the ideal society is anarchy in which no one man or group of men coerces another", and asks for reduced state activities. In general, freedom is seen as a very individualistic benefit limiting the behaviour of others against him. It is "negative freedom" viz. absence of coercion by the actions of other humans. This approach to liberty is not a unique idea of the New Right but a rather old one in the liberal tradition. In classical liberalism freedom is always defined in relation to the freedom of others (J.S. Mill 1926 p. 114 'On Liberty'), while the activities of the state towards the individual and society should be equally limited "since every law imposes some restriction on the natural liberty of mankind, which restriction is an injustice, unless legitimised by tending to their good" (o.c. 41 'Utilitarianism'). The term 'their' has to be seen in a broad sense because...

"...the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good either physical or moral is not a sufficient warrant." (o.c. p.73 'On Liberty').

In modern liberalism/libertarianism we can observe three points: a) that liberty is incompatible to taxation, b) liberty is closely related to 'free to choose' and c) that liberty is incompatible to the activities of state bureaucracy. These infringe and violate freedom, so they are 'a priori' 'bad' and undesirable things.

In the issue of New Right against taxation James Buchanan believes that "[a]ny politically determined transfer of income above minimal limits involves a coercive taking" (Buchanan 1975, p. 74), while in the "Consequences of Mr. Keynes" (1978) he suggests that

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28 In this case though Hayek is not that clear in his subject. Despite his desire for his points to have universal application, in this case he clearly refers to the White Anglo Saxon Protestant (or WASP!) and his abilities.

29 One of the main theorists of the New Right. He is a member of the 'public choice' school; Prof. at George Maison University and author of 'The Power to Tax', 'Freedom in Constitutional Context', 'The Limits of Liberty' 'The consequences of Mr. Keynes' and various other books and numerous articles.

30 The British NHS falls in all these three categories: a) In order to operate it needs to be funded by general taxation; b) its structure reduces freedom of choice as it is state run; and c) it is operated by a large personnel of all specialties. It is interesting that New Right theorists (Hayek, Buchanan, Lees) have used the NHS as a case study, or as an example of state bureaucracy, restriction of choice and factor inflicting high taxation in their work.

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Keynesianism has turned the politicians into imposers of high taxes and that this is detrimental for democracy (p. 27), while as far as the individual in society is concerned “[t]axes are levied on him, without his consent, to finance goods and services that he may value less highly than the foregone private-goods alternatives” (Buchanan 1975 b p.104). Taxation is coercive for Hayek (1963) as well but he assumes that this coercion is not as great as Buchanan\(^3\) for two reasons, necessity and predictability (p.143\(^3\)). Finally, Heald making an approach to the New Right’s views over taxation remarks that though public spending is one state activity the opposition to it is greater simply because “[t]he threat posed by public expenditure to freedom is a direct consequence of a definition of freedom in terms of free exchange within a market system” (Heald 1983 p. 58). The only acceptable expenditure and/or reason for taxation by the New Right (at least as Buchanan puts it) is the provision of the distinction between ‘thine and mine’ the protection of property or in other words “the collective provision of order (which) is productive” (Buchanan 1986 p. 167). This may contradict J. S. Mill who seems to have a marginally broader view of the duty of the individual in society. Mill thinks that the member of society has a duty “to bear his fair share in the common defence, or in any other joint work necessary to the interest of society of which he enjoys the protection” (J. S. Mill o.c. p.74 ‘On Liberty’; underlining by myself, the examples that follow in his ‘On Liberty’ though, do not indicate any particular duty to accept high taxation)\(^3\). In his “Utilitarianism”, he first claims that every human being possesses a certain form of dignity that is indispensable from him- (or her-) self and afterwards he postulates for the protection of this dignity. In the course of the text he indicates two causes of unhappiness which can and must be removed from human societies by the wisdom of society and the providence of individuals. These two calamities and enmities are poverty and illness. Another important question is the interpretation of his understanding of freedom. Is freedom (for Mill) only the absence of coercion on the political level, or the freedom from need and squalor as well? Mill himself adds in the issues concerning all human beings, the case of immunity from evil. For J. Gray though, the concept is much more narrow, including only protection of the violation of human rights, problems arising from despotic regimes and so on.

Even if we suggest the broader understanding of the term ‘freedom’ for Mill, we have to emphasise that at this stage he, as far as the way out of the problem of poverty and illness

\(^3\) He mentions that there was a great public outcry against taxation in USA in the ‘60s and 70s, a still continuing ‘taxpayer’s revolution’ (Buchanan o.c.91)

\(^3\) Adding the issue of army service.

\(^3\) There are two main questions arising from such an approach to the New Right ideology. 1) How much is the New Right compatible and in line with traditional liberalism? and 2) Was John Stuart Mill himself consistent in his ideas about liberty, happiness, utility and with the ways he offered to overcome the injustices of the society he observed?
is concerned, remains (mainly) individualistic. For J. S. Mill people must not undertake the task to be public benefactors, but they have to contribute to the happiness of the others surrounding them. Later on, in his ‘Political Economy’ he was to suggest some forms of state intervention such as taxation of luxuries for reasons concerning the common good, or some kind of compulsory accumulation in order to secure full employment (p. 357). But the state (in Mill’s opinion) can intervene and provide employment and subsequently happiness, (and later in the course of liberal thought in L. Beveridge’s by additional means), through two other ways; by colonisation and by devotion of the common land to small proprietors (p. 376). So, in our opinion Mill has an understanding of some form of state action towards welfare and happiness of the citizens. It is worth mentioning that the Fabian arguments of the early twentieth century to which we briefly referred in the first section of this chapter, can be seen as a continuation and expansion of the arguments of John Stuart Mill.

Another issue arising from the approach to public spending and taxation is that by state provision there is restriction to the freedom to choose, to which the New Right is opposed. This derives out of a more general observation of the New Right ideology and public choice approaches. It is implicit all through their literature; one of the main writings is called “Free to Choose” (Milton and Rose Friedman 1980). Such an approach by the new right is evidently clear in the confrontation to bureaucratic planning. The initial idea about planning being unnecessary according to the New Right theorists lies in the ‘invisible hand’ of Adam Smith’s “Wealth of Nations”. But in the New Right theorists the argument is stronger, and directed against state planning and control of the economy. This can be explained by the enlargement of state policies (which A. Smith did not observe). This change in the function of the state was observed earlier this century by M. Weber (who approved the growth of bureaucracy), and (among others) Schumpeter, Galbraith and Burnham (in his Managerial Revolution), who were highly influenced by Weber (Burnham being critical to the changes). Despite the lack of any clear reference (by the Public Choice scholars) to Weber or to the other scholars, we are inclined to suggest that there is some relation between them. The theorists with whom we are concerned claim that bureaucrats are ‘bad’ spenders of the money of the taxpayer and that they are trying to maximise their power via this spending of the money of the taxpayer, an allegation that is also directed to the politicians. The bureaucrats are alleged to have taken complete control over the procedure for spending and spending allocation and the politicians, having not been well informed over the issues, tend to vote for what the bureaucrats (who want to maximise their bureaus both for income and pride reasons) suggest. The question, when formed in another way, becomes related to classical political theory (Plato) as John Burton (in J. Buchanan -Ed-. 1978) asks what the problems will be if Philosopher Kings (bureaucrats)
end up being unsuccessful, while later on he raises the point of corruption (pp. 49, and 74 respectively). In the concluding essay of this book all three writers fear that politicians and bureaucrats “together, in the absence of constitutional constraints, they possess enormous potential of economic destruction” (o.c. p.80). But bureaucrats are not the New Right ideologists just because they (might) limit economic freedom and efficiency. For Friedman (1980 pp. 114ff) (who takes as his case study the NHS) we have a problem of inefficiency within the particular sector because the proportional growth in the NHS was larger for bureaucracy than for services to patients and the government bureaucrats try to enlarge their salaries through the cost recommendations they make to the national exchequer. Hayek is against any kind of national wide health provision, and he remarks that the national provision of health care

“is usually based on two misconceptions. They are first the belief that medical needs are usually of an objectively ascertainable character and such they can and ought to be fully met in every case without regard to economic considerations and, second, that this is economically possible because an improved medical service normally results in a restoration of economic effectiveness or earning power and pays for itself.” (Hayek 1960, p. 298).

Hayek’s disagreement is that we can not judge objectively either health nor the effort required to restore it, and that the restoration of health can be very expensive on the one hand and not taking interest of the alternative cost/allocation of expenditure on the other. For the NHS in particular he mentions

“the conception that there is an objectively determinable standard of medical services (…), a conception which underlies the Beveridge scheme and the whole British National Health Service, has no relation to reality” (ibid. p.299).

He maintains that an average service to all will mean reducing the best service already allocated to some, and that an average and standard service is a low quality service, while later on he mentions the dangers of the power of the medical profession (see Hayek, 1960 pp. 297-300). As Heald (1983) mentions, according to the New Right, the power of the medical profession (and the BMA in particular) in the NHS is great and ends up being costly, disruptive and reluctant to adopt introduced changes.

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34 J. Buchanan, R. Wagner and J. Burton; “The Consequences of Mr. Keynes” IEA 1978.
35 He particularly mentions the case of the hospital bed occupation by old and mortally ill, in such a way as to reduce the number of available beds for the young and repairable, (Hayek, 1960 p.299).
36 It is worth mentioning that the term bureaucracy —especially state bureaucracy is rather ill defined and unclear in the neo-liberal ideology. A ‘state bureaucrat’ might be either an economist planning in the Treasury, or a hospital consultant, or the doorman of the hospital.
In general there is great opposition to the welfare state. The welfare state policies are seen as coercive, contradictory, while there is a possibility of substituting them with charity to the poor which is “merely another consumption good” (Buchanan 1975 -in Seldon Ed- p. 74). For Buchanan the problem is that “like it or not, we live in an environment where the workings and forms of capitalism are tempered by the workings and forms of majoritarian democracy” (ibid. p. 75). As King observes -and referring to Heald -he mentions that for the New Right the welfare state diminishes freedom; and he adds that for the New Right freedom is a market freedom (King o.c. pp.36-37). The problems of poverty and so forth, are however acknowledged by the New Right theorists. The non-answers given though, range from Hayek’s renouncement of safety (see footnote 27 above) to the points that in order to achieve equality you have to coerce (as mention by King oc. 43); while the most applied answers are given by the Institute of Economic Affairs (one of the ‘Think Tanks’ of the Neo-Tories), as Heald (1983 p. 90) summarises: a) There should not be free services; if they are provided by the state, users should pay fees, b) Private provision should replace the public one wherever this is possible, c) Restoration of choice in the public sector can be achieved by the use of vouchers and d) Income redistribution should be in cash not kind. But for the health services in particular, Hayek mentions that their introduction is an irreversible decision and that these policies have to be continued after their launch (due to political cost) whether they are proven wrong or not (o.c. 298)7. These ideas about the supremacy of liberty over any other value in human life and society8 and the welfare state and planning being disruptive, coercive and ‘bad’ were adopted by Tory politicians as well. As Heald (o.c. p.7) cites Sir Keith Joseph (according to the Times the key Tory Theoretician) the problems of the British economic performance for the ‘dry’ Tories are

“ ...it isn’t as if our problem is simply that there’s been too much government. I reckon there are six, six poisons which wreck a country’s prosperity and full employment: excessive government spending, high direct taxation, egalitarianism, excessive nationalisation, a politicised trade union movement associated with Luddism, and an anti-enterprise culture. Six of them. Now some of our rivals have one of these poisons, some have two, we’re the only country in the world that has all six.”.

The Neo-Tory ideology follows very much the same lines as the libertarian theorists. The paramount principle for the Conservative Party after the mid seventies is ‘freedom’ very much explained (by the Tories themselves) as the freedom of choice. Sir Keith Joseph mentioned before the 1975 Tory Conference (see The Times 3/10/75) that freedom and prosperity are more important than the quest of equality;

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7 This irrevocability makes these policies ‘unacceptable’ by Hayek.

8 Once again we would like to mention the differences to J. S. Mill, who claims that the greatest values are “utility”, “freedom” and “happiness”. See footnote 13 as well.
"secondary purposes may differ. The primary purposes should be freedom and prosperity. The secondary ones can include issues like the degree to which you can reduce inequality without impelling private policy. The trouble at the moment is that the secondary have overtaken the primary in Labour's mind".

While later on he mentioned the problems by nationalisation and that the best way out is market competition. Mrs. Thatcher had fully endorsed the ideas of Sir Keith Joseph as early as July 197539,40, by being dedicated to free enterprise:

"There is an increasing belief that that is so: that you can have political freedom and economic slavery! That you can preserve intellectual freedom and destroy commercial independence! That you can fight for freedom of speech and yet overthrow freedom of enterprise. No myth is more dangerous. Freedom is indivisible. Once the state controls the means of production distribution and exchange, all of us become dependent upon it. The whole nation becomes dependent upon the decisions of the bureaucracy and the politicians."

And she continues that where everything is controlled by the state there is not freedom of choice, something she considers detrimental for freedom. These ideas lead to the privatisation assumptions and to the rolling back the state approaches (which in their extremes reach the ideas of private highways - Conference 1988, see Times 12/10/88 and Mrs. Thatcher in the 1990 Conservative Party Women Conference-). Another key issue for the Thatcherite Conservatives is low direct taxation. A general observation of the 1987 Manifesto confirms this view. The C.P. were proud of reducing taxes, and were planning more reductions (in direct taxation) and promotion of competition. Other proposals mentioned the development of private pension schemes (without touching the state ones) and commitment to law and order. About a year later, Mrs. Thatcher (in her 1988 Conference address) spoke about freedom, the abilities and importance of the individual and the need of a strong state in areas of defence and policing (see Buchanan, 1986 p. 167, mentioned above)41.

This is a very general outline of the contemporary Conservative Party ideology, which (as mentioned earlier) can be seen as the creator of recent changes in policies. In the late, seventies, and early eighties there was a considerable debate about the financing of the NHS by the National Exchequer and its replacement with 'voluntary insurance'. "The discussion (was) littered with abstract terms such as 'freedom,' 'choice', 'consumer

39 See The Times 2 July 1975, p.5 "Mrs. Thatcher espouses the Joseph credo".
40 It is a wrong assumption to think that the libertarian ideology appears suddenly in the Conservative Party. Key figures of the Tories were anti egalitarian and unhappy with the policies of the welfare state much earlier. See eg Peter Goldman (editor) "The Future of the Welfare State" 1958, or M. Ware "Is There an Alternative?" 1967.
41 King in his "New Right" shows this influence in greater detail.
sovereignty’ and the ‘market’, which seem to have little in substance for the practical man to grasp.”; John and Sylvia Jewkes were urging reform of the NHS on the grounds that it was restricting freedom (Gordon Forsyth in G. MacLachlan and A. Maynard 1982, p. 66). What we think as very interesting is the desire by the Tories to seem ‘radical’ or ‘revolutionary’ in their policies and ideas.

Contrasting the New Right ideology, there are two more ideologically strong arguments for the support of the welfare state policies in contemporary Britain, used by scholars unsympathetic to the changes (eg. King, Plant, et. al), the Fabian society and more widely by the opposition parties. These are the ‘citizenship rights’ and the ‘justice as fairness’ theories.

But now we turn to the application of the new right ideology in British policy making.

b): Taxation, state expenditure and legislation.

i) taxation and expenditure

According to the ideology of the New Right politicians and bureaucrats are bad spenders of money and they impose new taxes ending up in the coercion of the citizens. Additionally they claim that such a policy is unproductive as money is not spent (properly) or reinvested in economy so production faces problems. This subsection will firstly, attempt to examine whether the post 1979 Conservative Party governments were compatible with such an understanding of taxation policies (and subsequently of the state), and secondly to approach the levels of taxation themselves in order to relate it to our main argument that capitalism cannot live either with or without the state. To achieve this we will examine the

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42 Citizenship rights can be civil (concerning individual liberty), political (concerning the right to participate in politics) and social (or welfare rights). We will concentrate on the third for two reasons: a) they are the most relevant with our argument and b) they are “largely a twentieth century phenomenon” (King and Waldron 1988). Each citizen is bestowed with these rights to welfare (education, hospitals, security for employment, pension system etc.) just because he is a citizen. There is a great egalitarian claim as all people in a society have the same social rights regardless their wealth or social origin. T.H. Marshall introduced this idea in 1949. As cited by King and Waldron (ibid), he argues that “we ought to associate welfare with citizenship because our concept of citizenship will be radically impoverished if we do not. Citizenship, on this account, demands welfare provision; we can not have an adequate or attractive notion of citizenship without it.”, while Marshall himself defined citizenship “as a status bestowed on those who are full members of a community” (T.H. Marshall, Sociology at the Crossroads, London 1963 p. 87, see page 72 as well).

43 The Rawlsian argument for justice as fairness and protection of the people in need. In case these people are not well protected, then the society is unfair and unjust. Welfare policies can be understood as attempts to modify inequalities that exist in a society for a variety of reasons (fortune, inheritance or whatever). (See J. Rawls ‘A Theory of Justice’).

44 For a detailed analysis of this argument see Chapter 2, where we discuss our theoretical hypothesis.
levels of taxation\textsuperscript{45}, on the income of persons, corporate bodies and companies since the early post war period\textsuperscript{46}.

a) Personal Taxation.
This will show the (average) rate of income paid as taxation by earning individuals\textsuperscript{47}.

**FIGURE 1.**

\begin{center}
\includegraphics[width=.8\textwidth]{rate_of_taxation.png}
\end{center}

**SOURCE:** 'National Income and Expenditure' and 'National Accounts' CSO London relevant years.

As Figure I indicates, there is a strong upwards trend in most of the post war period with two interruptions in early to mid sixties and early to mid seventies, which were periods that the Conservative Party was in office. The top peak is in mid seventies during the first years of the Labour administration reaching some 15.67\% of total income, while there is a sharp downfall in the next few years, which coincided with the economic crisis and the general reverse of the policies of welfare by the then Labour Party government. Surprisingly during the first years of the post 1979 Conservative Party administration, there is a new

\footnote{To calculate the rate of taxation, we deducted the figures for ‘income after tax’ from those of ‘income before tax’ and calculated the outcome as a percentage of ‘income before tax’. (We have used the same method to calculate ‘rates of tax’ in the next tables). However, this analysis relates only to direct taxes. The rate of inland revenue to customs and excise has been decreasing (and is now much smaller) than in the pre-Thatcher period (see Financial Statistics January, 1962, Jan. 1975, Jan. 1980, Jan. 1985 and January 1991). The 1991/92 (Major/Lamont) budget followed this direction by increasing the VAT to 17.5\% to pay for the decrease of the Poll Tax.}

\footnote{While King (1987, pp 124, 125 -Table 7.3) mentions nationalisation as a state revenue.}

\footnote{Such an indicator faces a variety of problems as it does not show the actual levels of taxation per income stratum, or source of income, neglects the issue of people’s income bellow the tax threshold etc.}
increase in taxation (up to 1983) to be followed by a smooth reduction later. The level however remains as high as in the late sixties to early seventies period, and lower than the early to mid seventies period of the Heath governments, which were more committed to welfare spending than the Thatcher ones. A more detailed view of the recent years shows that

![Rate of Taxation Chart]

**SOURCE:** 'National Income and Expenditure' and 'National Accounts' CSO London relevant years.

the sharp decrease in the level of taxation coincided with the adoption of the IMF loan and the first austerity and public services cuts programme, while during the first years of the Thatcher governments there was even a small increase in the rate of taxation, although the rate of income for the top four classifications was slashed. It was firstly the Labour Party who after the economic and fiscal crisis, adopted policies that were more favourable to the earning of income, and possibly to the people with high incomes48, which according to a conventional classification can be called upper strata, or 'bourgeois'49 while the

48 Through a relative reduction of the rates of taxation in comparison to these of the few previous years (87.25%) for 1974-75, while for the other high incomes (four top classifications of Inland Revenue Statistics) the pattern is similar. However the rates of taxation are higher than for the late 1960s, early seventies, while the rate for the top incomes went back to the levels of the late 60s.

49 The definition of bourgeois is much more complicated than this classification implies. In many cases there is a confusion between class and stratum, though the two terms are methodologically different. Class refers to the relation to the means of production and to production itself (viz. control -or not- of production) while stratum to the level of income, education and opportunities for the offspring. It can be a difference between the two mainstream schools of social science the 'political economy school' and the 'behaviourist' one. It happens though, that there is a general coincidence between the bourgeoisie and the 'upper income strata', thus the confusion.

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(ideologically) anti-taxation Thatcher governments, increased taxation in the first budgets, and reduced it later. A point that must be stressed though is that the tax structure changed during Thatcherism to the benefit of the better off\textsuperscript{50} and that flat rate taxes (such as VAT) rose higher than ever before. Additionally, as Heald (1983) claims “unprecedented rates of inflation have distorted the tax structure, shifting the burden in ways not intended by policy makers, but which, for various reasons they have felt unable or unwilling to resist” (p. 283).

The examination of corporate and company taxation will give a clearer view of taxation policy insofar as the attitude towards the producing and reinvesting sector of the economy is concerned. Reduction in taxation (ie reduction in public spending) may mean that the government is trying to assist reinvestment of profits for the long term benefit of the companies and of the capitalist economy as a whole.

We will deal first with the broader sector of corporate taxation.

**FIGURE 2.**

**Corporate Taxation**

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{corporate_taxation_graph.png}
\caption{Rate of taxation on income of corporate bodies, 1945-90}
\end{figure}

*Source: 'National Income and Expenditure' and 'National Accounts' CSO London relevant years.*

In this case the great reduction is achieved long before the era of our main interest, between the mid and late fifties. After that period the band remained rather narrow, while the Thatcher governments slightly increased the rate of taxation. A post 1970’s picture of

\textsuperscript{50} 'There is a curious paradox. Income tax is a progressive tax because of its thresholds and rate band structure. But (.....) recent increments in tax revenue have accrued in a profoundly regressive way'. (D. Heald 1983, p. 286). See James Crowing and Terry Radke 1987, as well. In their essay 'The old and new policies of taxation. Thatcher and Reagan in historical perspective' (Socialist Register 1987) they analyse the rationale, ideology and vested interests for (Tory) tax policy in Britain since Pitt and the Napoleonic wars, which was the first time a 'modern' system of taxation was introduced.
corporate taxation shows that

![Graph showing the rate of income taxation, corporate sector 1970-89.]

**SOURCE:** 'National Income and Expenditure' and 'National Accounts' CSO London relevant years.

it was the Labour governments that were trying to keep taxation lower while the rate increased after the adoption of the IMF loan. The post 1979 Conservative governments increased corporate taxation to the highest levels since the late fifties during their first and second terms, while they reduced it slightly in the late eighties.

Company taxation.

This indicator is much clearer as it includes only the 'surplus value absorbers' in the economy. A more favourable taxation policy for companies aims to improve rates of capital accumulation and reinvestment. The capitalist contradiction between extraction of surplus value and capital accumulation (and reinvestment in constant capital) on the one hand, and reproduction of the productive capacity of the workforce on the other is clearly visible via this form of taxation (viz. state revenue) and state expenditure.

For the whole post war period the picture shows that
there was a general decrease in taxation after the early fifties with a main reversal in late sixties and early seventies, whilst once again the last Labour government offered lower company taxation to the ‘Moneybags’ than the Conservatives after 1979.

**SOURCE:** ‘National Income and Expenditure’ and ‘National Accounts’ CSO London relevant years.
Interim Conclusions.

If a reduction in taxation is explained as a policy in favour of the bourgeoisie, it was the Labour governments who tried to act in their favour by reducing taxation in the mid and late seventies. The cuts in expenditure (then mainly in housing and education) after the adoption of the IMF loan and the reduction in taxation signified the first stage of the bourgeois counter-attack which was later accomplished by Thatcherism. The issue of lower taxation (and expenditure) cannot simply be seen in narrow terms. By only examining the level of taxation, crucial issues such as the need for higher expenditure in certain areas, or the allocation of expenditure itself may be neglected. The rates of taxation have been higher during the years of Thatcherism51, but social expenditure had to be high in the early eighties due to high unemployment and subsequent payments of unemployment benefit. Law and order, and military expenditure (both been among the most expensive functions of government) increased greatly under the Tories, while the increasing cost of health care52 should not be neglected. In other words the Tories notwithstanding the needs for higher expenditure that raised partly from their own policies (Law and Order, Defence, unemployment), have been consistent to their ideology and have acted according to the general desire to reduce the burden on capitalist accumulation and reinvestment for the long term benefit of the economy, by keeping tax low and introducing (real) cuts in public expenditure as we will see later in this chapter53. However they could not achieve absolute tax elimination as both political and ideological reasons prevented them from doing so.

This thesis will concentrate on the issue of health expenditure and health policy in general, and the potential repercussions for the maintenance of the productive capacity of the workforce.

State expenditure policy

Now the thesis will approach the question of the allocation of expenditure between the various sectors of state policies during the years of the Thatcher governments. The aim of the subsection is to examine whether there are any particular sectors of the state policies that show expenditure or shrinkage in their finances in comparison to previous years. We will first examine the development of expenditure of three key sectors (Defence, NHS and Education) in standard prices for the past twenty years, and later their share of the total government expenditure for certain years of particular interest. Such an approach will

51 The rates for the upper incomes have been lower, though.
52 Increased expenditure for the elderly (see Chapter 3 for details), cost of medical technology, the treatment of AIDS, etc.
53 See eg King 1987 p.122 for public expenditure and health in particular. King refers to the problem of increase of expenditure under the Thatcher governments due to reasons beyond the will of the government, as the increased number of pensioners and unemployed for the Social Security budget.
indicate and highlight the emphasis given by the governments on each of the state functions.

![Graph: Government Expenditure, Various Sectors 1970-80 in 1975 Standard Prices]

![Graph: Government Expenditure, Various Sectors 1978-88 at 1985 Standard Prices]

**SOURCE:** ‘National Income and Expenditure’ and ‘National Accounts’ CSO London relevant years.

**NOTE:** There is a small incompatibility between some of the data in this source (e.g., Defence expenditure is mentioned for 1979 as £5102m (in one edition) and as £5106m in the subsequent one, and education (1979) £5029m and £5015m. However, the differences are minimal, especially if we consider the magnitude of the numbers and (mainly) that these differences do not obstruct the monitoring of trends in expenditure.
Defence expenditure remained relatively constant under both Heath and the Wilson/Callaghan administrations, while the two ‘welfare’ sectors in expenditure showed significant expansion and approximately levelled with defence in the late seventies (health being a little higher, while education shows a small ‘hiccup’ after 1976 due to the IMF loan). However the picture changes sharply in the post 1979 period. There is reduction in the expenditure for education\textsuperscript{44}. It lags well behind health and defence, the development of health expenditure is much slower than previous years (health expenditure to be examined in more detail in Part II). The increase in defence spending up to 1986 (when it faces a sharp downturn) shows a very rapid growth. Actually, after 1979 defence overtakes health by a considerable difference in terms of spending up to 1986. This indicates an important shift in policy making since levelling (and for a short time overtaking), between 1976 and 1979. Slow growth of education and health expenditure in conjunction to rapid defence expenditure growth indicate that the government did not want to ‘roll back the state’ (as such), but a particular sector of the state relate to the provision of services (which according to the New Right ideology infringe freedom) and to enhance another sector which provides ‘safety and security’ (which according to the New Right is the only legitimate role of the state). The rest of this chapter will examine whether this is an isolated incident or a rational pursuit of the Thatcher governments.

Another view of the development of public expenditure (and of the relative importance of each the major components) can be seen by examining the share in the ‘pie’ of public expenditure. We have done so for certain specific years. Our choice of years was based on two main assumptions. We started with the beginning of the seventies both because every first year of a decade can be a ‘chronological milestone’ and because it was the year Mr. E. Heath started his term. For the following years we have worked on the last year of each administration and the first (full) of following, plus 1982 which is a particular interest since it shows decline in the NHS expenditure in standard prices\textsuperscript{45}. Thus, we deal with the years 1970, 1974, 1975, 1979, 1980, 1982, 1984 and 1988 which is the last providing full data.

\textsuperscript{44} A possible cause of it lies with our data. For the 1970-80 period education is included in the general government expenditure, while for the 1978-80 period in local authorities expenditure.

\textsuperscript{45} See previous table and mainly Part II Chapter 2 “The National Health Service...”. Additionally, as we will see in the relevant chapters of the Thesis, increase of expenditure for the NHS throughout the Thatcher era, was lower than the one needed. These, in real terms, ‘cuts’ in the NHS expenditure have to be matched with the legislation and policies on the organisation of the NHS and the functions of the private health care option. We refer mainly to the Health Services Act of 1980, which is of significance for both the NHS (introducing limits in expenditure) and the PHIC (reallocating private wards in hospitals), while Acts that have particular significance for the private health care option are the ‘Nursing Homes Act’ of 1975 and the ‘Registered Homes Act’ of 1984. All these issues dealing with NHS legislation and expenditure, and the legislation about the private health care option and the expansion of the PHIC are analysed in more detail in Part II.
SHARE OF GOVERNMENT EXPENDITURE 1970

- OTHER 31.353%
- DEFENCE 26.653%
- NHS 21.018%
- EDUCATION 20.923%

SHARE OF GOVERNMENT EXPENDITURE 1974

- OTHER 32.848%
- DEFENCE 23.66%
- 21.177%
- EDUCATION 22.314%
SHARE OF GOVERNMENT EXPENDITURE 1975

- OTHER 33.389%
- DEFENCE 22.905%
- NHS 22.425%
- EDUCATION 21.977%

SHARE OF GOVERNMENT EXPENDITURE 1979

- OTHER 33.389%
- DEFENCE 22.707%
- NHS 22.425%
- EDUCATION 21.977%
SHARE OF GOVERNMENT EXPENDITURE 1980

OTHER 32.558 %
NHS 22.549 %
EDUCATION 19.301 %

SHARE OF GOVERNMENT EXPENDITURE 1982

OTHER 35.361 %
DEFENCE 24.624 %
NHS 23.563 %
EDUCATION 19.301 %
SHARE OF GOVERNMENT EXPENDITURE 1984

- OTHER 34.006%
- DEFENCE 24.742%
- NHS 23.457%
- EDUCATION 18.474%

SHARE OF GOVERNMENT EXPENDITURE 1988

- OTHER 35.963%
- DEFENCE 21.958%
- NHS 23.344%
- EDUCATION 18.734%

SOURCE: 'National Income and Expenditure' and 'National Accounts' CSO London relevant years.

NOTES: Particular care has to be taken for the years 1982, 1984, and 1988 as in the sources there is a distinction between 'central government' and 'local authorities' spending (the former including 'defence, NHS and other' and the latter 'education and other'. We have used the aggregate expenditure and the aggregate 'other'. Moreover the proportions for 1982 add up to 102.849%. Additionally the term 'other' remains rather general and vague. Desmond King in his 'New Right' offers a break down of some of these data (for the period 1980-85) to 'Law and Order', 'Housing' and 'Social Security' which shows a remarkable decline in 'housing expenditure' and increases in 'Law and Order' and 'Social Security' (the latter due to high unemployment). cf. King 1987, p. 122, table 7.2.
It becomes rather apparent that the sector that has suffered most cuts under the Conservative governments since 1979\textsuperscript{56} is not the NHS but Education. On the other hand, this current government has increased defence spending (with the exemption of 1988), and the share of defence in the national budget seems to be related to the Party in office as differences exist between the Heath and the Wilson (and Callaghan) administrations as well. The share of the NHS in the national expenditure has a (general) upward trend, with the exception of 1984.

Concluding on financial and economic policy\textsuperscript{57} at a more general level, it seems that the post 1979 governments have shifted some of the expenditure towards Defence and Law and Order and away from the provision of certain social services, such as housing and education\textsuperscript{58}. We will begin the examination of the changes during Thatcherism from these two sectors of public policy.

ii) Changes in legislation and policy.

In this subsection, we collect and compile information about facts and developments in current British politics that we consider indicative of the changes in post 1979 Britain, and relevant to our area of interest and approach. Thus, this subsection does not intend to form an in depth analysis of current British politics, but rather to serve as an informative background basis. We consider such a general approach necessary, because we believe that any particular policy, or set of policies\textsuperscript{59} has to be analysed and examined in the broader

\textsuperscript{56} Andrew Gamble in his analysis of “The 1982 Budget” in Capital and Class 17 (Summer 82) finds minimal changes, a reluctant retreat from monetarism in comparison to the previous years and the whole budget ‘CBI friendly’.

\textsuperscript{57} While Gamble in his ‘The Free Economy and The Strong State’ mentions that “the causes espoused...include strict monetary supply targets to reduce inflation, negative income tax, floating exchange rates, indexation, constitutional rules to enforce balance budgets and limit government spending, abolition of trade union legal immunities, reduction of income tax and abolition of progressive tax rates, privatisation of all enterprises in state hands, introduction of education vouchers, private health insurance in place of state support, and many more.” (Gamble 1988 p. 38). While his contribution to the ‘Socialist Register of 1987 (‘The free economy and the strong state’ as well) can be seen as a predraft of the book itself. Such an analysis of Thatcherism prevails in the whole of Socialist Register of 1987 which could be summarised as claiming that there is not just ‘more’ state under Thatcherism but ‘different’ state as well. See in particular the essays by R. Whitaker, “Neo Conservativism and the State” where a comparison with the USA (since 1981) is made, and Joll Krieger “Social policy in the age of Reagan and Thatcher”, where the individualist ideological framework and the centralisation prevailing in both countries are mentioned, while additional information can be found in Bill Schwartz’s essay ‘The Thatcher years’.

\textsuperscript{58} Simon Clarke in his article in Socialist Register 1987, (‘Capitalist crisis and the rise of monetarism’) claims that the changes can be explained better as a failure of Keynesianism rather than a triumph of monetarism, and mentions that these changes can not be explained by an analysis based on competing fractions of capital (‘fractionalism’: financial capital vs. industrial capital), an idea initially found in Clarke 1978 (more about Clarke’s 1978 article in Capital and Class 5 later in this chapter (footnote 88).

\textsuperscript{59} In our case the Mode of Health Maintenance which will be discussed in more detail in Part II.
context of overall concurrent political developments and not by itself, in isolation of other policies. We have included a broad spectrum of policies ranging from housing to government secrecy; and from defence to the latent ideology of the schooling system. Although these changes seem unrelated at a first approach, they have an intrinsic relation as they all are the application of New Right ideology at a policy making level, and they signify the bourgeois counter attack\(^2\) in contemporary British politics.

The changes in housing policy started (formally) with the introduction of the ‘Housing Act 1980’ (Chapter 51) which was “An Act to give security of tenure and the right to buy their homes to tenants of local authorities and other bodies”. Discounts were give if the ‘right to buy’ was exercised, while regulating details of the ‘right to buy’ and new offering of discounts were introduced by the Housing and Planning Act 1986 (Chapter 63)\(^1\). As mentioned by Marsh and Rhodes ‘by 1990 over one million-and-a-quarter council houses were sold’ (Marsh and Rhodes 1991, p.9), while they claim that the aims of the government in introducing such a housing policy were (among others) to minimise the provision of housing by the local authorities and to ‘reduce public expenditure on housing’ (ibid. p. 7).

The creation of the ‘home owners society’ is not the only change in housing policy and expenditure during the Thatcher years. There were cuts in housing benefit (at first the councils were not allowed to subsidise rents in their properties, later more cuts were introduced). However, housing benefit was only one of the ‘cash support’ policies affected. During the Thatcher administration, child benefit remained frozen for more than five years and changes in the provision of unemployment benefit were introduced by the Social Security Act 1989 which resurrected a rule of the 1920s according to which the claimant of unemployment benefit had to show that s/he was genuinely seeking work, and the claimant could not refuse to take a job on grounds of low wages (see Kathy Sutton, in Catterall 1990, p. 289).

In general there was a reduction of state provision of housing and benefits aiming at both a reduction of expenditure-taxation and to the ‘rolling back the state’.

Apart from the reduction of the share of the pie (of) and the minimal increases (in) education expenditure which we have just observed, there were some changes in the policy making as well. ‘Education Act 1980’ (Chapter 20 of the Statute Book) gave more parental power and opportunities for parental preferences\(^2\), while ‘Education (No 2) Act 1986’

\(^2\)This reference stands for the Trade Union legislation in particular.

\(^1\)These details for Scotland were introduced by ‘Chapter 65’ of the Book of Statutes.

\(^2\)The Tory ideological arsenal for education included (in the early eighties) the idea of the provision of vouchers which could be used by parents to pay for the provision of education for their children. ‘However, by 1983, Sir Keith (Joseph, then Secretary of State for Education) declared at the Conservative Party Conference that the educational voucher was dead’. K. Hoover and R. Plant 1989, p.174.
was ‘An Act to amend the law relating to education’ and increased parental power, introduced parents at the school board level and gave schools the opportunity to ‘opt-out’ of local authorities. The most recent is the ‘Education Act 1988’ (Chapter 40), which introduces the national curriculum, compulsory worship, and enhances the opting-out of schools to ‘grant maintained’. At a policy level it helps centralisation to the Department of Education and Science (see Keiron Walsh in Catterall 1990 p. 53 as well). Thus, the post-1979 Conservative governments have tried not only to keep educational expenditure under tight control, but to transform the system of provision of education as well. Though phenomenally the power of the ‘school’ and the ‘local authority’ (viz. the ‘state’) has been reduced this is matched by great centralisation to the DES in Westminster and the imposition of conservative principles such as compulsory worship.

An issue related to education, is training and the curing of unemployment.

There have been about 29 changes in the way unemployment is calculated (by the government) since 1979, so the reduction of the official number of the unemployed does not necessarily mean creation of new jobs, or less people out of work (Sutton, in Catterall 1990, p. 306)\(^\text{63}\). As A. Brown 1988 mentions there was great intervention in the training programmes and process by the Conservative governments which introduced the Young Training Schemes and later on the Jobs Training Scheme for the long term unemployed. These policies were aiming to the creation of a ‘model’ apathetic and manipulated worker and to the rigid control of the long term unemployed (See Brown o.c. pp 17-19). While, as mentioned a little earlier new restrictions to the claimants of unemployment benefit were introduced in 1989.

The other aspect of the government attitude towards employment is the policies relating to the Trades Unions and industrial relations, which underwent great transformations in the years of the Thatcher governments.

The Thatcher governments were determined to break the ‘beer and sandwiches at number 10’ tradition of the mid to late seventies, and to introduce tougher control over the Unions. The assault started as early as 1980 with the ‘Employment Act’ (Ch. 42) which introduced the secret vote for strike elections of officials and delegates and ended the closed shop. Additionally, it imposed restrictions in picketing and secondary action. The ‘Employment Act 1982’ (Ch. 46), can be called an ‘anti-non unionisation’ act, since it ruled that the dismissal for not being unionised was ‘unfair’. Additionally it restricted the meaning of the ‘industrial dispute’\(^\text{64}\), and it lifted the immunity of the Trade Unions from inductions and damages. In late 1983, the government started controlling which Union its employees

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\(^{63}\) Early retirement of the long term (and aged) unemployed is a clear and common example of the case.

\(^{64}\) Another aspect of this law is the integration attempt with the creation of the employee’s share scheme.
would participate to; Sir Geoffrey Howe said that “staff will be permitted in future to belong only to a departmental staff organisation approved by their director”65. The ‘Trade Union Act 1984’ (Ch. 49), made the ballot before a strike compulsory and imposed strict rules in this voting. Additionally, the law introduced restrictions in the sources of income of the Trade Unions. It was a law that not only imposed changes in the Trades Unions but, restricted their power and intervened to their internal affairs as well. While more restrictions were imposed through the Picketing Code (which mentions and limits the number of pickets, leaves them vulnerable to criminal prosecution, etc.) and the Closed Shop Code. As Basset 1986 (p. 117) sets it, in Britain there is not any ‘right to strike’66; there were only immunities to prosecution for strikers, and it is these immunities that have been attacked by the Conservative Government. (See R. Lewis 1986 pp.10, 52, 76, 183, 191, 202, 212-213 and Hoover and Plant 1989 p.182)67.

As part of the assault on the Trade Unions (and on the unemployed as we saw earlier), the contemporary Tory governments have introduced the ‘Wages Act 1986’ (Chapter 48) which abolished the wages councils and gave opportunities to the employers for changes (reductions) to wage settlements68. While as K. Sutton suggests there was the opinion that industrial relations were not improving but going back to standards of the 19th century with exploitative jobs and payment of low wages (K. Sutton in P. Catterall 1990 p. 297). It becomes apparent that the government aimed at (and achieved in) diminishing the powers of the unions and enhancing its own control over industrial relations.

The last69 set of policies to ‘dismantle the state’ undertaken by the Thatcher administration was the privatisation and the deregulation of the nationalised companies and services of the public sector. Some of these policies can be seen in relation to the assistance offered to the PHIC which we examine in the next Part of the Thesis, and to the ‘opting-out’ of the schools as discussed earlier in this chapter. These were introduced with the ‘Social Security Act 1980’ (Ch. 30) which provided for private pensions and the opportunities (for the potential pensioner) to opt-out of the state system of pension provision, while more

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65 Our quotation from Basset 1986 p. 59. Such a policy should be seen in relation to the adoption (by the state) of industrial relations similar to those in the private sector, (see Clarke 1988, p. 356). We believe that these changes strengthen our point about not only ‘more’ but ‘different state under Thatcherism.

66 While on the other hand the Greek Constitution in Article 23 gives the right to strike in an unequivocal and explicit way.

67 One of the major events of the Thatcher years, and of course the sharpest example of the confrontation between government and Unions was the miners strike of 1984-85 which ended with a great defeat for the NUM and the Unions in general. However, despite its importance (and worldwide publicity) the miners’ strike should not be seen as an isolated incident but rather as the tip of the iceberg of the transformation of industrial policy and industrial relations in Thatcherite Britain.

68 See Sutton oc. 301-302 as well.

69 Last for our approach, but certainly not the less important.

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changes were introduced with the 1986 Social Security Act, while a ‘life insurance tax cut’ was introduced on 6 April 1989 (See Budd and Davies in Catterall 1990 p. 144). But apart of this ‘opting out’ there was a large (re-)privatisation programme of the nationalised companies. According to Hoover and Plant the rationale behind privatisation was multifold. The main components of it were a) to ‘diminish the size and scope of government’, thus help the market on the one hand and the government itself on the other by limiting (and making more precise) its sphere; b) to increase economic freedom; c) to decrease the government’s role in pay settlements; d) to decrease PBSR and state expenditure and to increase capital for the state through the additional revenue from the selling of the companies; e) to increase efficiency and better use of resources and investment for the companies themselves; f) to create an enterprise culture; g) to lessen the power of the relevant trades unions; and h) to assist the whole of the economy by the combination of all previous reasons. The most important privatisations up to October 1987 were:

In 1979 British Petroleum (part)
In 1981 British Aerospace (part) British Petroleum (part) Cable and Wireless (part)
In 1982 Amersham International (total), Britoil (part)
In 1983 Associated British Ports (part), British Petroleum (part), Cable and Wireless (part)
In 1984 Associated British Ports (part), Enterprise oil (total) Jaguar (total), British Telecom (part)
In 1985 British Aerospace (part), Britoil (part), Cable and Wireless (part)
In 1986 British Gas (total)
In 1987 British Airways (total), Rolls Royce (total), British Airport Authority (total) and British Petroleum (part)

(Hoover and Plant 1989, pp.185-188).

After 1987 we saw the privatisation of the water industry, electricity (distribution at first and production later), the privatisation of (remand) prison catering and more recently plans for the privatisation of services of the British Rail and the privatisation of roads and bridges. Another aspect of the issue is the deregulation of some functions and the introduction of competition in certain services. For example the ‘Local Government Act 1988’ (Ch. 9) is

“An Act to secure that local and other authorities undertake certain activities only if they can do so competitively; to regulate certain functions of local and other public authorities in connection with public supply of works contracts;...”

While the Act to privatise the airports was passed in 1986; ‘Airports Act 1986’ (Ch. 31).

Some of these policies might remind of the ‘new’ GP contract and the ‘self governing hospital status’ introduced after 1/4/91. It is interesting that changes in health care policy, lag behind the rest of the public sector, probably due to strong legitimacy and sensitivity of the NHS.
and the private enterprise like management of state companies as coal and British Rail with the cessation of state subsidies and so on.

All these policy changes have assisted in ‘rolling back the state’ and in the creation of a ‘smaller’ (or ‘less’) state according to the New Right rhetoric. Though we would be inclined to agree that there have been changes in the scope of the state policies, we want to mention that what is ‘less’ is the Keynesian, Social Democratic and Corporatist state and not the ‘state’ itself. As we will argue in the rest of this chapter the British state remains rigid and interventionist (in some cases in an increased condition) in other functions and areas. These are the cases of centralisation of control and decision making from the local authorities to Westminster; the increased secrecy; the more rigid control of individual life; and, in terms of free markets, the intervention in the domestic and international money markets in favour of the Pound Sterling.

As Marsh and Rhodes (1991 p. 13) mention during the Thatcher years there were about 40 Acts passed through Parliament which dealt with local government (mainly its finances) and changes in the grant allocation system (incidentally between 1979 and 1983 there were seven changes to the grant system. As highlights of this centralist policy we would like to mention the “Rates Act 1984” (Ch. 33) ‘An Act to enable the Secretary of State to limit the rates made and precepts issued by local authorities’. According to this law the Secretary of State can impose levels of maximum expenditure for local councils, while another important assault on local government was the ‘Local Government Act 1985’ (Ch. 51) ‘An Act to abolish the Greater London Council and the Metropolitan County Councils; to transfer their functions to the local authorities in their areas and, in some cases, to other bodies;...’. There was a transformation of local power from the GLC to the London Borough Councils and from the Metropolitan County Councils to the Metropolitan District Councils, organisations which were not as powerful as their predecessors, thus we have a formal breaking of power to bodies that are closer to ‘the people’, but in real terms we have a diminishing of the power of the local authorities. The centralisation was continued with the ‘Local Government 1988 Act’, and we should not neglect the importance of the ‘Education Act 1988’ to which we referred earlier. The ‘jewel in the crown’ for centralisation was the 'Local Government Finance Act 1988' (Ch. 41) which transformed the method of collecting revenue for the local and district councils by introducing a flat rate

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72 See Hoover and Plant 1989 pp.169 ff as well.
73 For an analysis see Kieron Walsh in Catterall 1990, pp. 53-54.
‘community charge’; centralised more powers to the Secretary of State and extended his ‘capping’ powers. Some of the aims of the Conservatives according to Rhodes and Marsh (o.c. p. 12) were to control local expenditure as part of the overall strategy to reduce public expenditure; to strengthen the role of the ‘consumer of the service’; and to gain political advantage. At this point we would like to add the strategy of changing the state revenue burden from the rich to the less well-off. The state during Thatcherism did not just become more ‘central’. It became more ‘secret’ and, more ‘strict’ and ‘rigid’ as well by the introduction of the Official Secretes Bill. Thus the state became more inaccessible and ‘obscure’ than it used to be. But the state became more also rigid and strict by abolishing the right of the accused to make an unsworn statement and giving great questioning powers to the police (‘Criminal Justice Act 1984’ Ch. 48) and by introducing the ‘new’ offences of ‘riot’, ‘violent disorder’ and ‘tough’ and a more rigid regulation of demonstrations (Public Order Act 1986 Ch. 64).

Another clear indication of the conservativism of government (and of the New Right) was paragraph 28 of the Local Government Act 1988 which aims to ‘prohibit the promotion of homosexuality by local authorities’ (cf. Introductory paragraph to the Act) and mentions that the local authority is not allowed to ‘promote the teaching in any maintained school of...

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24 The flat rate community charge was nicknamed by its opponents the ‘Poll Tax’. Opposition to the system was so strong that the nickname achieved more common use than the legal official one, even in the media, its imposition caused riots in central London, about 30% of the people eligible refused to pay and last but not least was one of the reasons of the toppling of Mrs. Thatcher as Prime Minister on 22nd November 1990.

25 This strategy is indicated by the expansion of indirect taxation, the introduction of the Poll Tax etc.

26 This law classified as secret any information about some certain areas of state policy as ‘defence, security and intelligence, international relations, confidential government to government information, matters useful to a criminal, and official interception of mail and telephone calls’ (C. Seymour-Ure, in Catterall 1990, p. 74) while it made it an absolute offence for any member (or ex member) of the security and intelligence services to give information to the public and lifted the ‘public interest defence’ for those who disclosed such information (See J. Baylis in Catterall 1990, p. 134). The case is closely related to the publication of Peter Wright’s book ‘Spycatcher’. P. Wright (an ex Mi5 member) disclosed a significant number of inner policies of the organisation and the government tried to ban the publication; while another important case was the disclosure of the information about the sinking of the Argentinean boat the General Belgrano during the Falklands war. (See P. Dunleavy in P. Dunleavy et. al.-eds. 1990, p. 118-119).

27 A strong and rigorous critique of the ‘Criminal Laws’ is offered by Ian Taylor in the Socialist Register of 1987. Taylor (1987) attempts to correlate criminality with social problems. After correlating statistical data about unemployment (especially long term) and crime (especially for years 1984-85) he claims: “However, I do insist on there being an indissolable connection between crime (as a ‘real’ measure of social disorder) and the general condition of capitalist economy in England” (emphasis in original). Taylor’s essay is of particular methodological importance for our Thesis, as we attempt a rather similar approach to the MHM and the absence from the workplace due to health reasons. It raises the question - though from a different point- of the compatibility of empirical research with Marxist analytical frameworks. As Taylor himself puts it “(the nature of the relationship between the logic of the economy and social conditions is an important long standing theoretical query in both social democratic and Marxist traditions”. See Gamble 1988p. 134 as well.
the acceptability of homosexuality as a pretended family relationship'. This clause shows both the extension and scope of intervention of the central state over the local state and the educational system on the one hand, and the deep conservatism and authoritarianism on the other, since it is not just the teaching of homosexuality that is banned, but the teaching of its acceptability.

Trying to form an answer to the question of ‘less state (?)’ we have examined the increase of centralisation, secrecy, and rigidity of the state during Thatcherism. At this point it is worth reminding ourselves of the changes in the allocation of public expenditure discussed at the beginning of this chapter, since the policies of a more ‘strong’ state were matched with increased expenditure for defence and law and order.

After examining, however briefly, the interventionist functions of the state ‘qua state’, we would like to turn now to the relation of the state to the idea of the ‘free market’. The government has intervened in the functions of the ‘free’ market in two ways. Firstly by determining, through the Bank of England, the level of the interest rates for lending money (in most cases keeping them high in order to fight inflation) and secondly by buying Sterling in the domestic and international markets whenever the currency was weakening, thus keeping Pound Sterling artificially high (see eg Budd and Davies in Catterall 1990 p. 143 and Sinclair, ibid. p. 250). From our point of view such interventions are inconsistent with the free and self regulating markets ideology the government is trying to advocate. Strict monetarism as performed by the post 1979 (especially up to 1983) governments is a direct intervention and regulation of the (money) markets. The state has not stopped being interventionist. It has only changed its ways and areas of intervention making them more in favour of money capital (usually referred to as the ‘City’).

Having skipped through the information about the policies of the Thatcher governments we can now turn to the interim conclusions and to the question whether there was ‘more or less state’ under Thatcherism.

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78 In other words ideological system; see L. Althusser Ideology and Ideological State Apparatus

79 Such an approach to the Thatcher years may imply that there has been a complete dominance by the bourgeois class and a terrible defeat for the working class. However this is not the whole story. There was resistance to the bourgeois assault which imposed limitations to it. As highlights we can mention (a) for the private sector the Ford strikes in 1988-89 demanding (and achieving) high wage increases, and showing strong working class militancy and solidarity; (b) for the public sector the NALGO and NUR strikes which paralysed London and the South East during the so called ‘summer of discontent 1989’, and the great ambulance men strike which achieved overwhelming support from the general population and ended in a rout for the government, as in a more political level showed that people supported the non extinction of unions, which performed a significant shift from the early eighties (we do not mention the great miners strike of 1984-85 as it ended in defeat for the working class); and (c) the resistance to the Poll Tax which turned up to be one of the most massive movements of civil disobedience in recent years. At a more party political level, we can mention the swing of the electorate towards Labour, which can indicate even a change in class alliances as the middle classes feel betrayed by the bourgeois and turn to their ‘old’ (post war) allies.
Interim conclusions:
When trying to analyse ‘Thatcherism’, it should be borne in mind that it ‘seems to have acquired as many meanings as there are people who mention it’ (Jessop et al 1988 p.5). There have been though, two main Marxist approaches to Thatcherism. The first one is the ‘Authoritarian Populism’ approach launched by Stuart Hall (mainly) and Martin Jacques in 1983 with the book “The Politics of Thatcherism” (though Hall claims that the conception came in 1978) and the second is the ‘Two Nations Approach’ launched by Bob Jessop (and Kevin Bonnet, Simon Bromley and Tom Ling) as a response and critique to Hall (and Jacques).

The ‘Authoritarian Populism’ approach claims that Thatcherism as an ideology is a reaction to the political system of the seventies. It managed to identify itself as ‘the people’, and to orchestrate a reply comprising “of free market liberalism, with organic patriotic Toryism. ‘Free market, strong state, iron times’.”. This came as part and parcel with the imposition of law and order (S. Hall and M. Jacques, in Hall and Jacques 1983, p. 10). And later on in the same book, in his own essay, Hall mentioned the issue of populist moralism in relation to law and order (ibid. p.38). The approach, as Hall himself mentions, derives from the Gramscian theory, while in his counter reply to Jessop et al (see bellow) Hall claimed that he never intended to provide a general explanation of Thatcherism (see Hall, in Jessop et al. 1989 p. 99) and that he did not consider the Thatcherite Authoritarian Populism as a new hegemony, but rather as a new hegemonic project (ibid. p. 103 and Hall 1988, p. 7). He defended his use of the term by mentioning that (he)

“hoped by adopting this deliberately contradictory term precisely to encapsulate the contradictory features of the emerging conjecture: a movement towards a domative and ‘authoritarian’ form of democratic class politics - paradoxically, apparently rooted on the ‘transformism’ (Gramsci’s term) of populist discontents” (Hall in Jessop et al 1989, p.p. 101-102)

and that since ‘The Great Moving Right Show’ he has

“tried to show how Thatcherism articulates and condenses different, often contradictory discourses within the same ideological formation.” (Hall 1988 p. 10).

The ‘Two Nations Approach’, which as mentioned earlier was launched as a reply to the Authoritarian populism one, found many merits in Hall’s arguments, but tried to explore a different explanation of Thatcherism. A major claim is that we should make a periodisation of Thatcherism “in terms relevant to the complex dialectic between structure and strategy” and suggests three stages of Thatcherism: firstly its formation as a social force opposed to the postwar settlement (from the emergence of Thatcherism as opposition in the party to
Mrs. Thatcher’s election to Number 10); secondly the period of the process of its consolidation in the Tory party and government and cabinet (from its election to the Falklands victory); and thirdly its period of consolidated dominance attempting to transform British Society (Jessop et al. 1989, pp 18-20). Obviously the Two Nations Approach has more relevance for stages two and three. For Jessop, Bonnett, Bromley and Ling, Thatcherism has created a two tier society divided between North versus South, productive versus parasitic etc.

"Increasingly Tory populism is taking the form of unification of the privileged nation of ‘good citizens’ and ‘hard workers’ against a contained and subordinate nation which extends beyond the inner cities and their ethnic minorities to include much of the non-skilled working class outside the South-East. In this sense we believe that Thatcherism can be fruitfully seen as a ‘two nations’ project” (ibid. p. 87).

As the ‘Cambridge four’ explain, the productive sector are the producers of goods and services; and the parasitic the retired, the unemployed and those who work in jobs not profitable according to standards of capitalist accounting. As long as the policies hurt the ‘second nation’ they have to be matched with policing, repressing and authoritarian policies (pp.88-89).

The bibliography on the issue, and on the subject of ‘Thatcherism’ is extensive and most commentators of contemporary British politics have taken either the one side or the other. Since this thesis is not an attempt to analyse Thatcherism, but to examine the relation between a particular sector of the welfare state and the process of production, we will refrain ourselves from an in-depth analysis of the debate. However we would like to refer to the most important books of this debate: “The politics of Thatcherism”, Stuart Hall and Martin Jacques 1983, “Thatcherism. A tale of two nations” by Jessop, Bonnet, Bromley and Ling 1988 (including most of the essays on the debate in the New Left Review), “The Hard Road to Renewal” (Stuart Hall) and “New Times” (Stuart Hall and Martin Jacques).

‘More or less state?’
This question is derived from the New Right ideological rhetoric of ‘rolling back the state’. However we think that it is irrelevant to the recent developments and inadequate to trigger an answer in contemporary British politics. The question when expressed like this fails to address the very issues of what do we mean by ‘state’ and what do we mean by ‘more’ (or ‘less’). As we have already mentioned there has been a transformation of the functions of the Keynesian, social democratic, and corporatist state that was the dominant form of
administration by both Labour and Conservative governments since 1945\(^6\). On the other hand though, intervention of the state in the pursuit of control of the money float in the economy, consolidation and security of order, and achievement of uniformity (including ideological uniformity) has increased. As Gamble claims in his 'Free Economy...'"\(^8\)

"the great contradiction of Thatcherism is that in the circumstances of modern capitalism it is very difficult for the state to withdraw either economically or politically. Despite the anti-statist rhetoric the Thatcher Governments have proved remarkably interventionist and derigiste. The state has had to considerably strengthen in order that the Thatcher Governments can press ahead with freeing the economy."\(^8\)

According to A. Gamble the main tasks of the Thatcher governments were to a) restore the health of economic and social life, b) restore incentives, c) strengthen Parliament (in comparison to corporatism) and the rule of law, d) support the family and e) strengthen the British defence. And Gamble suggests that the first two involve the creation of a free economy, while the rest three others require a strong state (ibid. p. 121). Thus, we do not have just more (or less) state, but different state during Thatcherism.

The Thatcherite state is centralised, rigid and all policies are closely monitored by the government. Its expenditure is not lower than this of the Butskellite state, however it is concentrated on other areas. As R. Aitken\(^7\) has argued (referring to employment and training policies) "ironically, the return of the laissez-fair has assisted at the birth of a new form of a central state intervention", while Brown argues (referring to D. Robinson, 'Monetarism and Labour Market') that the labour policies of the Thatcher administration have to be seen in close relation to monetarism (Brown o.c. p. 36). Additionally, the needs of implementing monetarist theory and achieving cuts in expenditure created political problems between centre and periphery, and

"Thatcherism in office has become more interventionist and authoritarian towards the periphery. It has not proved sufficient to insulate the centre from the periphery, but the government has also been forced to take steps to control the latter more directly" (Jessop et al. 1988, p.38),

\(^6\) Usually, and especially for the sixties, referred to as the 'Butskellite' state and as the 'consensus state'. For Mrs. Thatcher "consensus seems to be the process of abandoning all beliefs, principles, values and policies" (as cited by Kavanagh 1987, p. 7)

\(^7\) Andrew Gamble, "The Free Economy and the Strong State" (London 1988). Gamble claims that Thatcherism has to be seen as a new hegemonic project (thus he is in agreement with Hall), but adds that there is a two nation tendency in it as well. He sees the importance of 'strong policing state to secure the 'free economy'. (see pp. 128 and 234-237 in particular).

\(^8\) Gamble 1988,p.p. 205-206; emphasis added. Though we are inclined to agree to this approach we would like to add though that the state is not only 'stronger' but 'different' as well.

while Hall 1988 sees the paradox of an ‘anti-statist’ Tory ideology and the need (and adoption) of an authoritarian state to implement it (p. 86). However, despite the anti-statist rhetoric, the Conservatives are the party that believes that their main task is to uphold the authority of the state, and they are not willing to compromise on this authority (Gamble 1988, p.170). The Thatcher governments have been quite consistent and in-line with the implementation of the New Right libertarian political theory and traditional Tory ideology. They have tried to ‘roll back the state’ and to ‘free the individual from bureaucracy’. Additionally they have enhanced the functions of the state that provide the distinction ‘between thine and mine’, as Buchanan asks for. However, there are a number of paradoxes and contradictions in this process of implementation. The state in order to be ‘rolled back’ in some areas (or sectors) has had to be expanded in others. This is due to the structure of the British state itself where a large part of welfare planning and expenditure is (or used to be) locally directed. As the objective was to control expenditure in the periphery, the central state ‘had to’ become more powerful and interventionist. The desire for safety and stability increased the powers (and expenditure) of the police and army and tighter control of individual life was introduced (also due to the fear of terrorism). These policies were matched with the inherited conservativism of the right wing of the Tories who advocated ‘traditional values’, ‘family life’ and anglocentricism. Last but not least the Thatcher governments seemed (at the level of the superficial) to refrain from market intervention, and to follow the ideology of the (revival of) ‘invisible hand’. However there was strong intervention through the monetarist and high Pound Sterling policies, and in this sense the post 1979 governments did not follow their ideological mentors.

The reason for these contradictions though, does not lie solely with the government itself. The phenomenon of a strong state and a (quasi) free economy and its incompatibility with the ideology from which it derives is intrinsic in the ideology itself. From our point of view the reason is that the New Right ideology and policy making have failed to define the state properly, by concentrating on the post war Keynesian-Social Democratic and Corporatist form of state and a critique of it through old liberal arguments. By ill defining the capitalist state, in its Keynesian social democratic and corporatist form as an ‘intruder’ and ‘oppressor’ and not as the regulator of the perpetuation of capitalist production, the New Right has missed the argument, and has failed to solve the long term problems of capitalism.

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*For a brief account see the relevant section in this Chapter.*

*The latter matched with the pro-americanism, anti-communism and xenophobia of the Thatcher governments on the ideological level.*

*Gordon Brown MP, (Labour, Shadow Trade and Industry) in his ‘Where There is Greed’ (Edinburgh 1989) misses exactly this point. Though he asks for more investment in training and infrastructure, he claims that this is a mistake of the government and not an inconsistency of the capitalist economy.*
As we will argue in our conclusions (Part III), the contradiction does not lie between the state and the individual (as the New Right mistakenly claims), but it is an intrinsic internal and inherent contradiction of capitalism itself. It is the contradiction between the extraction of surplus value and the accumulation of capitalised surplus value (on the one hand), and the securing, perpetuation and regulation of this extraction and accumulation (on the other). Additionally, state policies do not derive from only the needs and contradictions of capitalism. Working class resistance, class struggle and class alliances (which are ever changing) form a significant component in the process of policy formation. Politics has to be seen in an aggregate and combined form. All issues are interrelated and interdependent. Policies and politics are the results of a variety of other reasons (such as history of class struggles, changes ‘imported’ from another country, ideological changes -ideology might in some cases ‘imported’- and so forth) as well. As we claim in the introduction to this section, focusing on a ‘subject’ or an ‘area of interest’ is done for research reasons and does not and should not indicate or mean a ‘ceteris paribus’ approach.

The previous paragraphs approached the policies of the Thatcher governments on a variety of issues including defence, education, and trade unions legislation etc. The next one will attempt a brief analysis of the class alliances (and the attempts to achieve them) that triggered and imposed limits to these policies, and will relate these changes to health policies. Last we will offer our understanding of the contribution of class struggles to the formation of policy, as limits of these particular changes.

c) Policies indicating (or resulting in) a change of class alliances.

The Thatcher administrations were elected on manifestos promising ‘sound money’ and control of inflation. They tried to control the money supply to economy by reducing the PSBR and imposing high interest rates. This monetarist policy of high interest rates to control inflation and maintain a strong currency in the international money markets, is supposed to be ‘financial capital friendly’ and is associated with the needs and political strength of the ‘City’. As Geoffrey Ingham puts it in his ‘Capitalism Divided? The City and Industry in British Social Development’ (Ingham 1984) the City has been dominant in British politics since the mid eighteenth century and is still dominant. Ingham sees a dual division of British capitalism. Firstly, a division between ‘City’ and Industry and secondly a division within industry itself which (for Ingham 1984) is fragmented, thus powerless in comparison to the City. Moreover, Ingham sees the City as an international centre and not a national one, thus less vulnerable to national economy problems. The adoption of

\[\text{footnote: } 87\text{ Thus, politics cannot be neither forecasted nor predetermined.}\]

\[\text{footnote: } 88\text{ However there has been some controversy about an early end of monetarist policies either with the 1982 budget, or sometime midway in 1982. See, Gamble ‘The 1982 Budget’, King ‘the New Right’ etc.}\]
monetarist policies created a dual political problem for the Tories. Firstly, it indicates the struggle between financial and industrial capital, and the victory of the former over the latter. Industry could not (and still can not) expand at the level it wishes due to the high cost of money, the high cost of exports and the low cost of imports\footnote{For a critique to the 'fractionalist' approaches to capitalism see Simon Clarke, "Capital, Fraction of Capital and the State" in Capital and Class 5, where he suggests (with a reference to South Africa) that it is wrong to make such a kind of analysis as it excludes the working class from the political arena on the one hand, while the classification of the fractions of capital is incomplete on the other. (Ingham 1984 in pp 81-82 includes a short critique to Clarke 1978). The analysis that suggests that the policies of the Thatcher governments (and of any other government) derive from inter-bourgeois conflicts and clashes (interburgliche), which in the United Kingdom are the aforementioned clashes between the industrial and the financial capital, do not exclude the contribution/participation of the working class from the formation of policies, and do not exclude the approach that the policies are the outcome of class struggle. From our point of view, these policies just illuminate a different 'angle' or viewpoint of the problem of formation of policies. It has been suggested that the working class is fragmented either between foremen and workplace supervisors on the one hand versus lower personnel on the other, or in the post-fordist analysis between the 'core' workers and the 'peripheral' ones (see eg Aglietta 1979, p. 171). It is possible that there can be a similar differentiation and clash between different sectors of the bourgeois class. On the other hand, it could be argued that a class is 'internally divided' over some issues, while is united over others and especially when the crucial moment of confrontation with a 'rival' class comes the 'internally divided' class close ranks. }\footnote{While the resulting raise in unemployment is an additional factor influencing voting intentions and class alliances.}.*\footnote{Many people have either to lose their homes which is both a creator of life difficulties and of a feeling of disappointment and failure due to the ideological importance of the 'home owners' society, or to reduce their standards of living (eg not to take holidays abroad, or change the family car) in order to afford the mortgage.} This affiliation should be examined in conjunction with the attempts to control the Unions after the winter of discontent and on the party political level by the disarray in which the opposition parties found themselves during the early and mid eighties.
function and repercussion for the alliance of the bourgeoisie with the other classes\textsuperscript{83}, as it signified a change of attitudes of the bourgeois class, while the skilled workers, the ‘middle classes’ and the ‘white collars’ had a long tradition and legacy of alliances with the other parts of the working class and they had only recently allied with the bourgeoisie by voting Conservative. It was obvious that they would start turning to their old alliance when they felt that their new (and ephemeral) allies had betrayed them.

Last but not least, it could be argued that the changes in education and training policies had similar repercussions in the formation of class alliances\textsuperscript{84} as the members of the middle classes started feeling that Universities were not as easily accessible as they used to be (due to financial reasons) and saw their hopes for social ascent (or consolidation of this ascent) reduced. They also ended up blaming the governments and or party introducing such policies, so in class alliances terms similarly reconsidering their position.

These are some of the developments that manifest changes in class alliances\textsuperscript{85}, and can be interpreted as reasons for such changes. As mentioned earlier, the proper way to approach these developments is in conjunction with each other and not in isolation from one another, which could lead to simple and functionalist analyses of politics. In the next few lines of this subsection we will try to theorise from the developments in British politics themselves and offer a brief analysis of these developments.

This Chapter has examined the construction and reconstruction of the state and of the Keynesian welfare state in particular in the United Kingdom between 1945 and 1989-90,

\textsuperscript{83} Under the attempt to control and reduce local government expenditure and reduce taxation for the upper income strata, the government introduced a system which turned out to be a boomerang, as both the newly socially elevated skilled working class and the newly enlarged small private company proprietors felt worse off after the change of local government financing. Skilled working class people (along with white collars) could not afford paying the Tax or have had to make sacrifices from their style of living in order to afford it. The corner shop ‘entrepreneurs’ could not afford the UBR and felt that they were getting worse off in the benefit of other already better off fractions of society and the big businesses (eg department stores). See the approach to the local government revenue legislation in the previous section of this chapter.

\textsuperscript{84} Both the underfunding of the Universities and the ‘top up’ loans system. As we have seen earlier, expenditure for education has remained almost stagnant for the past years. This has caused an underfunding of Universities and other educational establishments. The developments of the expenditure on higher education had two results: a) lower level of investment, so lower expectations for a well qualified personnel positions in industry in future, and the destruction of hopes (and finances) of mid earning families for social ascent/ recognition of the offspring. The middle classes were among the main users of the universities after the ‘Redbrick Revolution’, consolidating a better social status for themselves.

\textsuperscript{85} Of course the changes in the MHM and the NHS should be referred to here, though they will be examined in great detail in the following Part II. Apart of the ideological importance of the NHS already mentioned in the Thesis, many people feel that the NHS has been neglected by the government, and that they cannot afford private health care (unless as part of a wage package) especially in the light of the previous two developments in the family expenditure. This ends up with reconsiderations of the potential alliances also, which in this particular case include the ‘producers’ of the service as well (See Part II Chapter 3 referring to the analysis of the class alliances round the welfare state by LeGrand and Goodin).
and has attempted to explain the changes in terms of ‘application of ideologies to policy’ and class struggles. Though ideology can be an important ‘trigger’ for change, and despite the problems of the New Right ideology to identify the state, we would not agree with R. Parry (in Drucker, 1986, p. 209) who claims that

“the limitations of the Conservative social policy is that the New Right thinkers who have heavily influenced the Conservative government do not have a coherent policy strategy for social services, and the actions of the government often fail to correspond to the ideology they profess”.

Parry’s analysis, though not wrong as such, is inadequate because he does not give the reasons of incapacity of the New Right ideology (which is their wrong understanding of the state), and neglects the issues of class struggles and alliances to which we have referred and the problems of the cost of securing the extraction of surplus value, to which we will refer to the rest of this Thesis.

The next Chapter will examine the questions that arise from the application of our theoretical framework (Chapter 1) and the observation of contemporary British politics (this chapter) with particular reference to the issue of health. Additionally, it will approach the sources used and discuss their possible shortcomings and compatibility with our research project.
CHAPTER 3.

"QUESTIONS, SOURCES AND DATA"

INTRODUCTION.
This chapter will discuss the questions to be approached in the rest of the thesis, (in other words our particular case study), and the sources of data we used for this research, and will also describe the limits of our data. The Chapter consists of two main sections the first one dealing with the questions of the thesis, and the second one with the data, sources and the way we have approached the data in the rest of the Thesis. Finally, there is a short recapitulating paragraph, reminding the key argument and questions of the project.

SECTION 1:
"The Questions"
Our observation of the changes in contemporary British politics¹ and our approach to the questions of ‘reproduction’ and ‘class struggle’, together with the controversy about how to conduct the application of the latter to the former, give rise to the main questions of this Thesis and research project. One of the key policies for what we call ‘short term reproduction’ is the way the productive capacity of the workforce is maintained on a day to day basis. Assuming that the main requirement of such a maintenance is good health (which assists low absence from the workplace) we will concentrate on the set of policies aiming to ‘repair’ the health of the workforce. We call this way through which the health of the workforce is maintained, the “Mode of Health Maintenance” (or MHM). In Britain the National Health Service has been the main component of the Mode of Health Maintenance since the war; while private health care has increased its share in the MHM in the recent years.

The obvious questions arising are whether the recent changes in the MHM have influenced the maintenance of the productive capacity of the workforce, and thus whether the state by

¹ As mentioned in the Introduction to the Thesis, we are going to concentrate only on the policies of the Mode of Health Maintenance and of the National Health Service, and their repercussions for the ‘productive capacity’ of the workforce, for reasons of control of the empirical material available.
attempting to reduce taxation and expenditure has undermined the capitalist system by depriving it of a healthy and productive workforce. Or on the contrary whether our theoretical understanding of state policies as the regulators of reproduction and the outcome of class struggles is wrong because it can not be corroborated by any evidence. An additional question is whether the transformation of the welfare state, and of the MHM in particular is in line with transition towards a ‘post-fordist’ society (or even more whether it proves the ‘existence’ of such a society itself). In such a case the (ideal typical) MHM would be that the health of the ‘core’ workers workers is maintained through company paid subscription to the PHIC, while the NHS remains neglected and underfunded looking after the ‘peripheral’ workers. The next Part of the Thesis will attempt to relate the changes in the NHS\textsuperscript{2} to morbidity and absence from the workplace for health reasons on the one hand, and the development of the private health care option on the other. Secondly, we will examine the privatisation of health care provision in the light of the needs of capitalist production and of the so called “transition towards ‘post-fordism’. Finally, the third question relates to the use of empirical data for theoretical purposes. (The treatment of this issue is implicitly in the whole second part of the thesis; this issue is not addressed in any particular chapter).

To approach the first question we will concentrate on issues such as health expenditure with particular emphasis on the changes of health expenditure in standard prices, and on the legislation on the operation of the NHS. This approach will assist our evaluation of the ‘quality’ and ‘quantity’ of the NHS. To see the results of these policies we will examine the levels of morbidity in the British population and (what is more important for our theoretical framework) the rate of absence from the workplace due to health reasons. Finally, we will examine the class struggles and alliances in relation to health policies (and to general politics as well). Such an approach to the first question will help us examine our theoretical hypothesis that the policies of the Keynesian Welfare State, and of the National Health Service in particular are the outcome of both the needs of capitalist production (and of their contradictions\textsuperscript{3}) and of class struggles and alliances\textsuperscript{4}.

Thus, the thesis will deal with three main questions. Firstly, with the changes in the NHS and the impact of these changes in the process of reproduction (and thus on the process of production) and the limits given to the changes by the very needs of a healthy workforce for capitalist production on the one hand and class struggle on the other\textsuperscript{5}.

The second question will be examined by an approach to the development of the Private

\textsuperscript{2} Especially NHS expenditure.

\textsuperscript{3} It will assist in proving these contradictions as well.

\textsuperscript{4} Thus, it will assist our critique to the School of German Derivation.

\textsuperscript{5} Part II, Chapter 1.
Health Insurance Companies, the expansion of their activities and functions, and of their market objectives. Finally we will compare the PHIC with the NHS and we will examine their relation. Such an approach will show the function of the PHIC as far as the maintenance of the productive capacity of the workforce and of the key ‘core’ workforce for a ‘post fordist’ norm of capitalist production is concerned. Is it that the MHM has turned towards a two tier system in which the ‘core’ workforce\(^6\) is insured by their employer?\(^7\)

The answer to the third question is the Thesis as a whole. Our main purpose is to show that political theory should be the outcome of political research and analysis, or in other words a theorising out of the existing world. Thus, we have to apply our theoretical concepts, presuppositions and hypotheses to (each time) contemporary politics in an attempt to (re)evaluate them. As we mentioned earlier, in order to (re)evaluate our approach to politics (as the outcome of the contradictory needs of capitalist production and class struggles and alliances) we will examine the trends and tendencies in a part of the welfare state -namely the health policies- and we think that the best way to achieve this is by the use of empirical data on our area of interest.

Having examined the pursuits and objectives of this project, we will now approach the sources and data which we will use and the issues of the ambiguity of these data and the danger of being misled by them in our approach to the problems of politics.

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\(^6\) This insuring has a dual appearance. On the surface it seems to be a fringe benefit offered by the employer to his ‘highly trained’ and ‘good’ personnel. However, as far as our analysis is concerned it is that the employer insures the ‘productive capacity’ of a certain part of the workforce, because this ‘core workers’ are now on the important ones for the valorisation of capital.

\(^7\) Part II, Chapter 2.
SECTION 2:
"Sources and Data"

Since political theory* is the theorisation of the political world we have to approach the existing policies, trends, legislation etc. As it is beyond the ability, subject and project of the Thesis to conduct original research in the form of questionnaires or widespread personal interviews, we will rely on already collected data on the issues. Pursuing this thesis we have approached, apart from the theoretical approaches to the state discussed in the review in Chapter 1, a variety of sources both primary and secondary. The secondary sources are commentaries on British politics, while the primary (which are of more interest) are mainly Crown Publications. The primary sources can be further divided to ‘policy related’ sources, that is Commission Reports and Acts of Parliament (which are usually in a ‘text’ form), and ‘policy results’, related sources (which are mainly in ‘numerical’ form). A third category of sources that can be identified with both of the previous two is the ‘expenditure related’ sources. These are in numerical form, and they could be understood both as a manifestation of economic policy (this manifestation being in a numerical form), and as a result of economic policy (the policy being in text form, eg the Budget Speech)*. The rest of the primary data are provided mainly by the PHIC and are both in a numerical and text form10 or by other private organisations closely related to the PHIC (such as the Fitzhudge Directory) and by the Confederation of British Industry11. In particular, data about the population of the United Kingdom were taken from the ‘Annual Abstract of Statistics’ of the Central Statistical Office; data about the Gross National Product, income (all personal corporate and company) and expenditure were taken from the ‘National Income and Expenditure’ of the CSO (after 1984 renamed as ‘National Accounts’ or ‘The Blue Book of CSO’); data about morbidity were taken from the General Household Survey; and data about absence were taken from the ‘Social Security Statistics’. Our main concern when using those sources was to have continuity of information

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* Here in the sense of state theory. We use this term because we believe that the distinction between the two is idealist and artificial. Political theory has always been a theorisation of what the state (and our relation to the state) is or should be. Talking of ‘political theory’ per se is depriving it of its analytical and critical qualities.

* However, this is a minor detail and any further treatment will be in the realm of the pedantic.

10 At this case we should refer to one interview we conducted with Ms Stephanie Dunbar, of the Western Provident Association (Scotland), while the other two leading PHIC (BUPA and PPP) refused our request. See Appendix for more details.

11 In text form, due to the lack of numerical data on one of our initial areas of interest. See Appendix.

12 This reference stands for the graphics of Part I, Chapter 2 as well.
regarding all years between the mid and late 1940s to late 1980s\textsuperscript{13}. We have used Central Statistical Office (and other HMSO publications) data because we believe they are the most accurate and ‘unbiased’ ones, and they covered most of the needs of our project. All data that were in numerical form have been set up in appropriate time spans (with particular emphasis on the post 1970 and post 1979 periods) and reproduced in line graphics\textsuperscript{14}.

The Ambiguity of Data.
Another problem closely related to the one discussed above is the question of how accurate the statistical\textsuperscript{15} data can be especially if we want to make comparisons with earlier periods. This applies particularly when much of the data were either collected differently from today, or the social conditions themselves vary from one era to another. It is not only the statistical data that can be doubtful. Even the economic/financial\textsuperscript{16} data can be -though clear-potentially misleading. This can happen because the data showing spending never include the reason for the increase in spending. In the introduction some causes of increased spending on health -such as the AIDS problem, the changes increases in the cost of medical technology- are mentioned.

A) The financial data.
In the case of the financial data there are two main issues to be considered. Firstly, it is the changing of certain social conditions and circumstances that provoke the need for a change (in most cases growth) in health spending (in many cases though this increased spending goes to other age groups than the ‘productive’ ones)\textsuperscript{17}. And secondly, the growth of spending itself, and the rate of this growth, which can change from year to year and has to

\textsuperscript{13} So in most cases we have not used each annual edition, but about one out of five. This caused a minor problem as in some cases data given about one particular year (say 1955) in one edition (say the 1957 one) differ from the data quoted for the same year in a later edition (say the 1967 one). However the differences are minimal and do not disturb our understanding of the developments in the particular area in the long run.

\textsuperscript{14} At the ‘technical’ level we can mention that the software system used was ‘Cricketgraph’ of Apple Macintosh. The combination of the two different software systems (Macwrite II and Cricketgraph) has caused wide margins around some of our graphics. This results to a number of blank spaces in certain pages containing these graphics.

\textsuperscript{15} An old Greek University joke claims that the Professor of Statistics in his opening lecture said to his students: “Ladies and Gentlemen, Statistics is the science which at the given moment you were to put your head in a freezer and your feet in an oven you could prove that you have the correct temperature around your body.”

\textsuperscript{16} The term statistical data is strictly referring to approach to human behaviour, activity etc.; financial and economic data refer to revenue and expenditure figures.

\textsuperscript{17} The necessity of the existence of a healthy workforce is not the only reason for the adoption of health policies. Ideological and political factors contribute to this matter as well.
be examined in net terms (ie excluding inflation). Finally, we should pay attention to what the source of this increased expenditure might be. “The spending figures for 1991-92 will probably be supplemented by money raised through income generation schemes, estimated to be £70m. The revenue for such schemes (for example that of leasing space in hospitals for commercial enterprises) plus the cash increase will have to cover all the various demands on the health service budget” (ibid as footnote 18).

a) Changing spending in a changing world.

The needs of health care change either with the appearance or with the eradication of a disease, or with the changes in the cost of medical technology, etc. However, these are not the only factors. Social (predominantly demographic) factors can contribute to the need for increased spending also. According to Ray Whitney MP19

“It (the average age in the non geriatric wards of the NHS hospitals) usually turned out to be around seventy. A few young men would have broken their legs playing football or falling off their motor bikes but the majority would nearly always be in their seventies, having their second hip replaced or their cataracts removed” (cf. R. Whitney 1988 p.14).

The following graphics will show the important changes in the population structure of the United Kingdom, and will indicate the needs for higher expenditure due to these changes. Firstly we will observe the changes in the age structure of the British population for the whole century.

AGE STRUCTURE OF POPULATION OF THE UNITED KINGDOM 1901-1990

SOURCE: Annual Abstract of Statistics and Population Trends relevant years. Data for 1990 (Population Trends) not classified between 75-79 and 80-84, but only as 75-84.

18 This can be rather important. “For every 1% rise in inflation the NHS will need to find over £200m in 1991-92” BMJ Vol. 298 p.408.

19 Previous Minister for Health Services at the DHSS
which shows a significant increase in the ‘expensive’ health care ages. While a more detailed analysis of the development of the third age population shows


![Graph showing age structure of the population of the United Kingdom from 1900 to 2000.](image)

Source: Annual Abstract of Statistics and Population Trends relevant years. Data for 1990 (Population Trends) not classified between 75-79 and 80-84, but only as 75-84.

that the population of over 65 has increased almost fourfold (3.91 times), while the population between 75 and 79 has increased by 5.22 times (up to 1981, data for 1990 missing) population between 80-84 by 5.84 times (again up to 1981) and the over-elderly population by 14.19 times! (up to 1990). Moreover, while the age group 65-74 shows a flattening of its increase after 1981, the other groups show a considerable increase from 2225 thousand to 3114 for the combined age groups for 75-84 group (as the 1990 classification), and the over-elderly increase by 1.53 times over this decade.

An approach to more recent developments in the age profile of the population shows the
increasing financial burden for the NHS more clearly

while the third age detail shows the increases over the past twenty two years

and the increase of the task of the NHS to provide health care for all. Though the age group between 65 and 74 show a small decline in the early eighties all other age groups show increase.

C. Ham (1982 p. 45,) gives information similar to that given by R. Whitney and adds that

"with the proportion of elderly people in the population growing annually, an increase in the NHS budget in the order of 1 percent per annum is required to keep pace with the increasing demands of an aging population”.

This was officially acknowledged in 1988 by Ministers who claimed that

"health authority services need to grow by about 2 per cent a year in order to meet the pressures they face. One per cent is needed to keep in pace with the increasing number of very elderly people (.....); medical advance takes an additional 0.5 per cent and a further 0.5 per cent is needed to make progress towards meeting the government’s policy objectives” (Letter from Mr. B. Hayhoe, Minister of State for the DHSS to the House of Commons Social Services Committee; our quotation form HC 264-1 Feb.1988).

The Committee claimed (after the answers given by Mr. Jones -Director of Health Authority Finance-)

"that the necessary rate of growth per year changes according to demographic changes. In early 1980s required less than 1% growth....but ...years 1987-88 to 1989-90...will necessitate growth in services of 1 per cent”

while the main reason for this is the number of the elderly (ibid.). Finally the Committee noted that

"it appears that to meet both inexorable and policy pressures, services need to grow, and that at present20 the best available estimate of the scale of that growth is approximately 2 per cent a year” (ibid.).

So, life expectancy has risen tremendously in the recent years. However, this should not be approached only as an achievement of the NHS. It also creates a certain number of problems to the NHS, since the older people need health care more regularly (and in some cases for longer periods) than the younger. Moreover the cure of the elderly can cost more than the cure of other age groups. In 1981 the costs per person by age group and sex were:

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20 February 1988.
<table>
<thead>
<tr>
<th>AGE</th>
<th>MALE</th>
<th>FEMALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNDER 1</td>
<td>£473</td>
<td>£386</td>
</tr>
<tr>
<td>1-4</td>
<td>£178</td>
<td>£157</td>
</tr>
<tr>
<td>5-15</td>
<td>£111</td>
<td>£100</td>
</tr>
<tr>
<td>16-24</td>
<td>£114</td>
<td>£111</td>
</tr>
<tr>
<td>25-44</td>
<td>£126</td>
<td>£131</td>
</tr>
<tr>
<td>45-64</td>
<td>£193</td>
<td>£184</td>
</tr>
<tr>
<td>65-74</td>
<td>£407</td>
<td>£370</td>
</tr>
<tr>
<td>75+</td>
<td>£772</td>
<td>£947</td>
</tr>
<tr>
<td>ALL AGES</td>
<td>£192</td>
<td>£222</td>
</tr>
</tbody>
</table>

(excluding maternity-obstetrics, in patients and out patients, and midwifery-administration and capital costs)²¹.


As far as the total population of the whole country (and not only the ‘wards’ population) is concerned,

"in terms of age groups, the proportion of the population under 20 increased from 20.5 percent in 1951 to 23.9 percent in 1977 before starting to decline; in absolute numbers an increase of 10.3 to 13.3 million. This relative low and standard school age population contrasts with the number of those aged over 65, which increased from 5.5 million in 1951 to 8.3 million in 1980, or from 10.8 to 14.7 percent of the population. The number of these 75 and over has doubled between 1951 and 1984. The total number of elderly will remain stable over the next two decades, due to the low birth rates in the 1920s and 1930s, but its age profile will become older and thus increasingly burden some to the health and social services.” (cf. R. Parry 1986).

While for the period between 1979 and 1990 the ‘expensive’ health care population (over 75, no further classification) has shown an increase of 1.53 times.

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²¹ This might very well mean that the cost for women of the 16-64 ages might be a little higher.
to an approximate population of 3,933,000 people.

All these demographic, technology cost, and medical reasons make the change/increase of/in expenditure for the health sector rather binding; so the claims about increased spending by the government should be taken 'cum grano salis' (see also BMJ vol. 298 p. 409).

b) Calculating the change of spending.

As already mentioned in this case we have to consider two different indicators. The first is the growth of expenditure itself and the second the rate of this growth per year.

i) the growth of expenditure is expressed in terms of the money allocated for health expenditure per budget. This money may well be increasing in the course of years. The aspect to be approached in this case is the proportion of the national budget allocated each time for health. Is it growing or not? This is a first and in some sense superficial approach to the issue. What we think as more important in order to examine the policies of a government is

ii) The change of the rate of growth in the various years. This can show whether the government not only allocates more money to health than it used to, but whether the increase in this allocation is larger than the previous one. Of course these data should be examined in the light of the issues about the demographic, cost etc. factors raised in the previous section.

This approach will be followed in both sections of this Chapter concerned with research into the issue of jeopardy of production due to absence caused by health reasons (and even more by insufficiency and inefficiency of the Mode of Health Maintenance).
B) The statistical data.

There are various indicators (literally each source has its own indicators!) as far as the level of health is concerned. What is of great interest is to relate these indicators to our argument, as the classifications made in the original sources do not coincide either with each other nor with our theoretical framework\textsuperscript{22}. We are mainly interested in the number of days lost due to illness.

The main indicators are:

a) As far as the issue of days of restricted activity is concerned: a) the long standing (or chronic) illness and b) the acute illness. These terms appear in the General Household Survey and days of restricted activity have been classified according to these two ‘categories’ of illness for many years. We will approach the days of restricted activity due to chronic or acute illness, as mentioned in the General Household Survey. We think that this is one important though not clear indicator as the restriction might be in activities concerning leisure and not working time. On the other hand though, it is the only indicator that has some form of social classification.

b) Secondly we will concentrate on the actual point of focus which might be understood as the outcome of a and the performance of the NHS as discussed in the previous section. The days lost per year in the process of production due to ill health, as referred by the Social Security Statistics (CSO publication) which does not mention class, but we think that there is not any particular problem as the data are referring to days lost from the workplace.

We will use two terms as far as health level and efficiency of the MHM (currently being mainly the NHS) is concerned. These two terms are “long standing” (or “chronic”) illness and “acute” illness. Although the terms sound rather clearcut, we think it necessary, to define them.

a) Long standing or chronic illness. Unfortunately there is not a clear definition in the GHS itself. It is just that in the GHS the two terms are used interchangeably. As illness we understand “disease: unhealthy condition of the body: Illness makes one weak”\textsuperscript{23} and as chronic or long standing: “continual, standing for a long time” or “which is extended in the same form for some time”\textsuperscript{24}, while for the case of acute illness we have a clearer definition by the GHS itself (1972-76 and 1979-87 editions) “as the restriction of normal activities as a result of illness or injury. Informants were asked about any such restriction during the two weeks before interview”\textsuperscript{25}. As previously mentioned we have another definitional problem (especially in relation to absenteeism) in the term limiting. In the GHS there is a

\textsuperscript{22} See last paragraphs of Chapter 1 of this part especially footnotes 19-21.


\textsuperscript{24} Same source as above, duration not mentioned.

\textsuperscript{25} Our quotation from the 1984 edition p. 123.
distinction about the long standing illness between the limiting and the non limiting one. We will not be concerned with the latter, as it does not seem to create any (at least easily observable) problems to production. On the other hand, acute illness is limiting by definition.

The ambiguity of the statistical data can be either due to their collection or to changes in circumstances in the society where they have been collected over the years. Or even due to the way the questions (to the respondent) themselves are formed and what issues are (or are not) raised in them.

a) In the case of collection we can have either a ‘bad’ or ‘unscientific’ collection of data26, which makes the data themselves useless, or change in the way or technique that the data are collected and/or classified in different periods. This can make the comparison of data between different periods difficult or even impossible. Unfortunately, this is the case for the period of interest, since the technique has changed in the past ten or twenty years we are going to examine. There are some certain issues about this problem. One of the main differences is the shift from the number of people reporting restricted activity, to the number of days of restricted activity per annum, per person (this change appears in the 1976 GHS onwards)

“In the 1977 health section, health problems have been categorised by the effect on peoples lives, whereas up to 1976 illness was categorised by the disease that caused it, in so far as this could be ascertained by the respondent. (....) A major departure from the method of questioning used in previous years was that as part of the initial questions used to establish the presence or absence of ill health, respondents were shown check lists of common health problems of symptoms” (GHS 1977, page 80).

In some cases the GHS is concerned with the use of medication which is something totally different from restricted activity and from the absence from the workplace due to health reasons. On the other hand the ‘collectors’ (Central Statistical Office, BHS, GHS etc.) had so many years experience and developed such a good reputation both in Britain and worldwide that we think that this danger is not so great as it might at first seem to be. Of course, the way the data are presented makes them incompatible with each other, but as we are going to ‘cross examine’ our data from a variety of sources the mistakes of the ‘collectors’ will appear in the form of great deviations and differences.

b) The other and maybe more important problem can be the absence of, or ambiguity about the reasons for the change in the statistical data themselves. In health metrics we can see better life expectancy during the recent years is not an achievement of the NHS only. It

26 Produced after wrong sample collection, viz not having the same possibility for any member of the population examined to be a member of the sample group.
should be correlated with the changes in housing, in nutrition and smoking habits, with safety in the workplace (less accidents) the various anti infection and sanitation policies etc. (cf. G. Forsyth 1983, pp. 6-7; on matters concerning nutrition, smoking and drinking habits, cf. Social Trends 19-1989 edition pp. 121-124; and about the whole issue R. Klein 1983 pp 167 ff). What is very important in Klein’s argument is that the statistics about health show mostly how many people die, of what reason, in which age. They do not show (and they can not show) how do people live (oc. 167). This is very clear in the first editions of Social Trends where the classification is according to disease as reason of death, while in later editions the data are mainly taken from previous editions of the GHS (see Social Trends 1-4 and 5 onwards respectively). Equally there is no mention of the social dimensions of the problem. As the Black Report has shown health is very much class determined. Health problems of different classes need different treatment and -of course-different amounts of money and different allocation of this money. This can not be shown in statistics, and perhaps it can not be achieved by an all population covering (viz. National) health service. On the other hand there is the problem of pollution that has been (according to some people) a great claimant of lives (while according to others the problem was solved in the mid fifties with the substitution of coal with gas for central heating), the car accidents etc.

Last but not least we have to take into consideration the variations of the human factor. Days of restricted activity of patients can depend on how well organised the GPs are27 and on their own work restrictions. Another problem is that in some cases GPs refer patients to hospitals without any particular reason (Cartwright 1967, p.129), so we can have an increase in both the number of the outpatients and the days of restricted activity without real problems in the way health is maintained; equally though, most of the GPs work long after 5:30pm, and a significant number of people (especially working class) meets them at that time of evening (ibid. 105). This can create some more problems to the clarity of our data about absenteeism due to health reasons. On the other hand, doctors themselves say that about 25% of the visits paid to them are trivial, inappropriate, or unnecessary (ibid. pp.44-48, 121, 219). So, we can have either reports by the respondent that s/he visited his/her GP, or even that s/he took a day of for health reasons -viz. for a visit that proved to be inappropriate etc.- without having ill health in our population.

c) Earlier in this chapter we mentioned the problem of the ‘unasked questions’ during data collection; issues like satisfaction or dissatisfaction with one’s own job can cause more or less days of restricted activity due to illness (obviously, if you do not like your job, you

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27 There have been cases reported that the GP ‘forget’ to visit a patient (at the home of the latter) for some two or three days, simply because he could not be anything better than a ‘terrible timekeeper’ (see A. Cartwright, 1967 pp. 8-9).
try to avoid going even in the case of a sore throat) while though most people were satisfied or very satisfied with their jobs in November 1971 according to Social Trends 1973 page 39) (GHS 1974), or (contrary) cases of physical appearance in the workplace in places/times of high unemployment and threat of lost jobs in case of absence (Cartwright oc. 105).

d) The three previous paragraphs dealt with the problem of accuracy of data and (the third one) ‘unasked questions’ in particular. In this paragraph we will refer to the problem of ‘unanswered questions’. These are questions we tried to pursue during our research, but did not manage to get any answers from the organisations approached. There were a couple of reasons these data were not available to us: lack and ‘commercial sensitivity’. This lack of data produces difficulties for any research project, since we cannot have any concrete basis on which to comment and to relate our analysis to the theoretical presuppositions we have set in Chapter 2. The most important data we did not manage to collect are data regarding the days absence from the workplace due to certified illness as a percentage of planned days of work for that year; and the social classification of the PHIC subscribers, especially for the case of skilled manual workers (C2) and the form of payment of their subscription (through their employer as part of a wage package or through a Trades Union). The first kind of data which the Department of Employment ‘did not hold’, could have helped us assess the impact of changes in the MHM after allowing for unemployment and changes in industrial policy. The second kind of data were not known to Ministries of State that we approached and to the CBI and the TUC, while in some cases we were advised to contact the PHIC themselves. In this attempt the data became ‘commercially sensitive’ and ‘not disclosable out of the organisation’. These data could have assisted in the analysis of the transition to ‘post-fordism’, as we would have had evidence about transformation of the MHM as far as the ‘core workers’ are concerned28.

Some comments on the data about social classification.
The most obvious case of this problem though is not with the days of restricted activity etc., but with the very issue of social class and classification. On the one hand in some of our sources we do not have any classification at all. On the other hand the ways of classification in the Social Trends and in the GHS and their (non) compatibility with Marxist terms. Most of the data we are going to examine are classified in six “classes” that are not clearly related to our methodological approach. This is the most crucial point as far as the Thesis is concerned. The evaluation of the existing data by ourselves. The classification of the respondents in the sources has been made in six classes:

28 See references in the particular Chapters and sections and Appendix for more details.
a) Professional; 
b) Employers and managers;  
c) Intermediate and junior non manual;  
d) Skilled manual and own account non professional;  
e) Semi skilled manual and personal service;  
f) Unskilled manual.

We will approach the data for the health records of the four latter socioeconomic groups and not classes because we are interested in health records of the 'producers' than of the 'conductors of production'. This is due to two reasons: a) from our point of view the 'conductors of production' are so valuable to the process of production that they will not be left unattended (this derives both from our theoretical understanding of their position in capitalist production and from the observation of the various fringe benefits the employers give to their managers), and b) we want to concentrate on the producers themselves since all commodities are products of human labour; so, if human labour ceases to be efficient then production of commodities faces disruption. We will try to overcome the problem of incompatibility of the class and the socioeconomic group analysis by concentrating on the skills factor which we consider as rather important for the development of our argument. In this approach we try to approach the workers according to their ability to work in the transformed workplace, or in other words to the automised 'post-fordist' one. In this case skills are necessary so the distinction between intermediate and junior non manual, and skilled manual and own account non professional on the one hand, and semi skilled manual and personal service and unskilled manual on the other is quite clear and adequate. Of course we should be cautious not to include all the skilled workers to the 'post-fordist' ones. Skilled workers exist in the fordist workplace as well. Unfortunately, statistics mention only if the worker is skilled or not; they do not mention what skills (s)he has got.

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29 There has been long and endless discussion in politics whether the managers should be included in the bourgeoisie or not. Such an issue is out of the interest of this Thesis. From our point of view the important issue is that the managers whether they are members of the bourgeoisie or of the proletariat are highly skillful contributors (this term is very wide; a contributor to production can be either a worker or a capitalist who 'offers' the means of production) to the process of production (they could be called even the 'conductors of production') so they are precious for capital because it is difficult to replace them.

30 The white collars! Do they belong to the working class or do they form another sub-class or whatsoever? From our point of view the white collars do produce values in the form of services, so they do produce surplus labour (even if their product is not tangible). So we can just remain in the observation of the expansion of the third sector of the economy; and possible to a new form of capitalism (it should be emphasised that post industrialism does not mean non industrialism).

31 We prefer this term for two reasons: a) in the sources themselves they are cited as 'socioeconomic groups' and b) we would rather use the term class taking under consideration the relation of the 'classified' person to the means of production and his class consciousness as well. Alternatively, when referring to the CSO categorisation, we will use the terms social stratum, social class(ification), and socioeconomic group.
CONCLUDING REMARKS.

Chapter 1 claims that the state is bound to be contradictory, since it is the outcome of two factors which are themselves contradictory or conflictual, and seem to be in conflict and contradictions with each other. The needs of accumulation are contradictory since there is a contradiction between the extraction of surplus value (which creates accumulation) and the securing of this extraction (which sustains accumulation). Class struggle (here in the sense of working class resistance) comes as a hindrance to the extraction of surplus value and to specific ways of securing this extraction, while it is more favourable to other ways which are more expensive for capital. These contradictions, and the contradictions between extraction of surplus value and securing the perpetuation of this extraction can lead to the case that “of course state rulers, in pursuing what they conceive to be their interest, and the ‘national interest’, may use the autonomy they have to adopt policies and take actions which turn out to be disadvantageous or disastrous for everybody” (Miliband 1983, p.67). For our thesis and approach to Thatcherism this is exactly the case. The ‘state’ after 1979 had little constraints to adopt policies as the traditional power bases of the working class (Trade Unions and the (left of the) Labour Party) were unable to sustain the attack. What we will examine in the rest of this Thesis is whether this ‘autonomy’ (from class struggle especially up to late 1988 for the preservation of the MHM) and the decision to help the dominant class by reducing expenditure\(^3\) (for health) in order to achieve cuts (or at least not to increase) taxation worked out to be ‘disadvantageous and disastrous’ for the manufacturing bourgeoisie.

\(^3\) Or at least not increase in the previous -and ‘required’- pace. See Part II, Chapter 1 for the full analysis. For a general approach to the policies of the Thatcher governments see previous Chapter 2.
PART II

"THE CASE STUDY: THE MODE OF HEALTH MAINTENANCE"
INTRODUCTION.

Part I examined the developments in British politics and the theories about the construction and the importance of the Keynesian Welfare State and the National Health Service in particular, and claimed that the latter was (and probably still is) the major component of the Mode of Health Maintenance. The last Chapter raised a number of questions relating to the NHS and the changes in the NHS to intrinsic and inherent needs and contradictions of capitalism and to the limits imposed by class struggles.

This Part of the Thesis will examine these theoretical questions and hypothesis. We will apply our theoretical framework, questions and presuppositions to contemporary British politics and undertake a concrete case study of the British Mode of Health Maintenance.

There is a multiplicity of objectives in this Part of the Thesis, however the main ones are two ‘research’ objectives and one ‘methodological’. The first objective is to examine whether there has been any jeopardy or hindrance of production by increased morbidity and absence due to the changes in the NHS. In other words to examine the relevance of the ‘Capital Logic School’ and the applicability of the ‘inherent contradictions theory’, and the ‘class struggles theories’ to contemporary political developments. The second ‘research’ objective, is to examine the process of privatisation of the MHM in relation to the argument about the transition towards a ‘post-fordist’ society. The methodological objective is subtle and exists within both the other arguments and analyses. It is the claim about the importance of empirical and applied backing, proving (or disproving) of a theoretical framework. This Thesis seeks to reintroduce the validity, importance and necessity of case studies on specific issues in order to achieve a re-evaluation of theoretical assumptions about the capitalist state and its policies and politics.

Part II is divided into three Chapters. The first deals with the changes in the NHS and NHS funding in particular, and the issues of morbidity and absence from the workplace due to health reasons. The second examines the growth of the PHIC and the argument about transition to a ‘post-fordist’ health care system according to which the vast majority of the population will be in the ‘second tier’ of the MHM (this being an underfunded NHS), while the ‘core’ workers in the ‘first tier’ (this being the PHIC), while their employer will be meeting the bills. The third Chapter brings all the arguments together and concludes on Part II, raising points of discussion for the concluding Part III of the thesis.

This part is based Part on empirical data. Most of our data originate from Crown and Government publications (CSO, HMSO) and from sources related to the PHIC. The data are discussed in more detail in the relevant Chapters and sections.
CHAPTER 1


INTRODUCTION.

The objective of this chapter is to examine the growth (or shrinkage)\textsuperscript{1} of the National Health Service, and the achievements and results of the whole of the Mode of Health Maintenance\textsuperscript{2} in its efforts to maintain the productive capacity of the workforce by keeping the workers healthy. There are two main questions to be answered in this chapter. First, whether the NHS has undergone any significant changes in its functions and funding since its construction in 1948, and since Mrs. Thatcher’s ascent to power in 1979 in particular. The second question relates to the maintenance and restoration of the health of the population itself since we are concerned with the days of restricted activity and the days of absence.

\textsuperscript{1} The question that occurs under this topic is: “growth” what? and of course “shrinkage” what? If growth just equals inflation then we might have shrinkage (not real terms of expenditure but) in terms of level of the MHM, since the needs are going up as well -see later in the chapter -. If we have an increase that matches the increase of needs we do not have an expanded or increased service, but an equal/standard level of health maintenance. In general a growing NHS will be an NHS with a growing share in the national budget and with growing expenditure and services in comparison to the growing needs. Of course this is difficult to prove, since there are not any statistical indicators for this purpose. Such a growing NHS can be indicated by a growth in expenditure and share of the national budget (while this is not absolutely necessary as the growth of the budget itself might be such that there will not be any need for growth in the share of the budget to meet new needs), and mainly by a growth in the expenditure at standard prices. A shrinking NHS will be a NHS which remains relatively stable, and/or has undergone some unimportant cuts, so it will be shrinking in comparison to the growing needs. A dwarfed NHS is the one which is undergoing severe cuts in its expenditure and investment.

\textsuperscript{2} As there are no separate data regarding the morbidity levels and absence from the workplace due to health reasons for the PHIC subscribers any distinction between the two is almost impossible. On the other hand despite the ongoing growth of the subscriptions to the PHIC (see next Chapter 2) the NHS remains the main provider of health care in Britain.
from the workplace due to health reasons. In other words, the second questions asks whether there is any jeopardy in the process of reproduction of the productive capacity of the workforce and consequently any potential problem in the process of capitalist production. The Chapter is divided into three sections, the first examining the NHS (legislation, structure, financing, equipment and personnel between 1948 and 1989-1979 and 1989 in more detail), the second examining the morbidity of the population and the days of absence from the workplace (answers to these questions are dependent on availability of data which is rather poor -see special section 2-) and thirdly a section concluding on the whole Chapter³. The Chapter compiles mainly primary sources which are predominantly Crown or Government publications and publications of organisations directly affected and interested in the issues such as the Confederation of the British Industry (CBI). These sources are discussed in more detail in the relative parts of each section. Additionally, some secondary sources are used mainly in the form of commentaries on the primary ones.

³ While a comparison between spending for health and morbidity and absence is given in third Chapter of this Part, “Conclusions on Part II”.

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SECTION 1:  
"The National Health Service".

This section will be divided into four main subsections, the first dealing with the history of the ‘legal’ development of the NHS and the second with its finances. The first subsection is subdivided into two periods; one examining the changes between 1948 and 1979 and the other examining the changes from 1979 to 1989. The subsection on the finances of the NHS consists of a large number of tables dealing with all aspects of financing a health care system by the national exchequer, while each individual table (and its analysis that follows) is divided according to the periods we want to highlight. The same stands for subsection 3 which deals with the ‘facilities’ offered by the NHS in terms of doctors, dentists, nurses, midwives and beds; and for subsection 4 which deals with ‘level of services’ of the NHS viz. the duration of treatment and the days of morbidity (days of restricted activity due to illness).

Sub-section I  
Legislation.

This subsection will examine the legislation about the NHS after 1948 with particular attention to more recent developments. What will be examined is not just the laws themselves but also the various Reports on the NHS. The most important changes in the pre-Thatcher period were in 1968, 1973 and 1976. Consequently this subsection will be divided into two ‘paragraphs’ the first dealing with the 1948-79 period and the second the 1979-1989 (31/1), while the White Paper “Working for Patients” and the new system which is under development since April 1991 will not be discussed in this Thesis, despite the considerable controversy (and moreover its political and party-political implications) about the ‘creeping privatisation’ of the NHS through the ‘opt out’ system, and the problems and financial failures of the ‘opted out’ hospitals.

at 1948-79.

In these first thirty years of the NHS there were some very minor modifications made in order to improve efficiency of the service, while in some other cases there were some small

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4 The approach to the legislation on the creation of the NHS exists in Part I of the Thesis.

5 “An inevitable feature of the reorganisation is that its effects take some time to become evident, and available statistical information does not always keep pace with the changes. It would therefore be unrealistic to make a comprehensive assessment of the success of the reorganisation at this stage....” Ruth Levitt in her preface of her “The Reorganised National Health Service” 1977. We think that such a statement is valid for the recent changes in the NHS as well, especially when seen under our particular ‘productive capacity maintenance’ viewpoint. This is the very reason we are not going to discuss the current changes in this Thesis.
changes in the cost of prescriptions, spectacles etc., without threatening the ‘free access’ of the less well off, through a large number of exemptions and rebates.

The most important Acts were -as previously mentioned- the 1968, 1973 and 1976 Acts. The 1968 Act (which was the first major Act after 1946) did not provide any radical departure from earlier legislation, mentioning only the management of private beds in hospitals provided they would not disrupt the ‘egalitarian access’ to the service.

The most important piece of legislation post 1948 was the 1973 Act. Yet again, it was not in itself any great departure from the system. It was mainly a reorganisation of the control and management of the system without challenging the NHS itself. Better efficiency6 was the main aim. The 1973 Act is a long detailed paper covering some 100 pages; it took quite long to develop as a project for health since it is in line with the recommendations of the three Reports of the Joined Committee(s) on the Organisation of the Work in Hospitals (known as the ‘Cogwheel Reports’), the Report of the Working Party on Medical Administrators (known as the Hunter Report) and the Management Arrangements for the Reorganised Health Service (known as the Grey Book)7 which cover a period between 1968 and 72. The key issues in the Reorganisation of the NHS were the introduction of the greater involvement of the doctors in the running of the NHS and the composition of the Regional Health Authorities (RHA), of the Area Health Authorities (AHA) and of the Area Health Authorities (Teaching) [AHA(T)] where Universities or medical schools existed. A closer examination of the developments shows that the main recommendation of the three Cogwheels was that there should be more involvement of the doctors in the running of the organisation of hospitals and greater democracy in their workplace. This could be at a two tier system both in their own specialties (Cogwheel structure in each specialty) and at a general level for the hospital as a whole, where all specialties should be represented. Such a project could result (and this was the will of the Committees) in a dual function for doctors as ‘curers’ and ‘administrators’. The participation of junior medical staff, nurses and GPs was also recommend since it could provide links and consequently better understanding between the different specialties in the NHS. This system required supporting services (secretaries etc.), but even according to its inventors was not an exclusive system, but general values and guidelines which should be adapted to the particularities of each area. The initial ‘Cogwheel’ structure was planned for hospitals, but it could be expanded to groups of hospitals too. Though regions are not mentioned ‘expressis verbis’ in the

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6 Another unclear term. It is some times related with low cost, without mentioning short stay at hospital or ‘healthiness’ as such. In the only cases short stay at hospital is mentioned it is in a way ‘short stay vs. cost’ and as a managerial problem (see Efficiency in the Hospital Service, Office of Health Economics, London 1967). In the 1973 Act though, there is a hinted implication of ‘health as happiness’ (achieved through short stay etc.) meaning of efficiency, and subsequently aim of the government.

7 All these documents are going to be referred to by their ‘nicknames’.
Reports, we think that the expansion to this level was not incompatible with the idea of the Reports. The aim of cogwheel was ‘efficiency’; i.e. better services in and out of hospitals. There was no great consideration of cost reduction. The idea is for best services within the limits of available resources. The Hunter Report had as objectives the unification of all services at each level and their administration from a single authority, which could lead to the integration of services previously separated; the development of high standards in health and care; the national, regional, and local definition of needs, in order to set clear standards to achieve and, finally, the provision of better links of the health services with the local authorities. It was believed that “clinicians (would) wish and need to be involved in these decisions”; and according to the reporting committee, it was vital for the doctors to take part in the administration of the health services (Hunter Report pp. 12,13, 49; quotation from p. 15).

As previously mentioned, the reform or reorganisation of the NHS was in line with the recommendations made in these Reports. The 1973 Reorganisation Act provided a kind of decentralisation matched with increased control from the Secretary of State for Health and Social Security. In general it created a ‘pyramid’ system of organisation and control with more participation of doctors and local representatives at the lower levels, and great accountability upwards to the Secretary of State (Management Arrangements for the Reorganised Health Service, HMSO, 1972, and Ruth Levitt 1976, p. 25). According to the Act itself, the

“Regional Health Authority is representative of persons of any of the following categories, namely-
(a) the medical practitioners of the region; or
(b) the dental practitioners of the region; or
(c) the nurses and midwives of the region; or
(d) the registered pharmacists of the region; or
(e) the ophthalmic and dispensing opticians of the region,
then, subject to the following subsection, it shall be the duty of the Secretary of State to recognise the committee; and a committee recognised in pursuance of this subsection shall be called the Regional Medical, Dental, nursing and midwifery, Pharmaceutical or Optical committee, as the case may be, for the region in question.” (1973 Act; see Book of Statutes 1973 p. 450).

The RHA should consist of representatives of: the areas of the region viz. the county councils, and the metropolitan district councils; the university (or universities) of the region; the local trade unions -to the discretion of the Secretary of State- and the local charities (ibid. 498), while the composition of the Area Health Authorities should be quite similar (499).
Concluding on the 1973 Act we can suggest that in order to increase efficiency, a pyramidal structure of the NHS was formed, matched with participation of doctors of all specialties and the local authorities. Thus was more democratic procedure introduced into the system and the most key issue was that

"all those concerned with the management of the service (were) keenly conscious of major deficiencies and of gross disparities in the availability and quality of services. Some still (thought) that the solution to these deficiencies (was) simply to increase the amount of money the nation spends on health. More money, better buildings and more trained staff are undoubtedly needed, but it is equally important to ensure the effective utilisation of the resources that (were) already available" (Hunter Report p. 7).

Thus, the idea was not to reduce spending, but to achieve better use of the money. The people most capable of accomplishing this objective were the doctors, due to their experience with health.

Last Act in the pre-Thatcherite period was in 1976. It is an Act without any particular importance for this Chapter of the Thesis, diminishing the number of pay (private) beds at the NHS hospitals and promoting more egalitarian ideas. This Act does not signify any departure from the core ideas of the NHS, on the contrary, it was related to the manifesto of the Labour Party promising the abolition of 'private "pay" beds', and signifies a return to the original 'core' ideas of the NHS and the strength of the working class during that period.

Recapitulating and concluding on the 1948-79 period we could suggest that there were no important changes in the NHS over these years. There was greater interest in the expansion and consolidation of the NHS and on the egalitarian ideas of the system than in cost reduction.

b) 1979-88.

There were some considerable changes over that period. There were five Laws passed from Parliament about the NHS, only three of which are of interest for this research. The most important is the 1980 Act, since it introduces a great deal of changes both in the formal system and organisation of the NHS, and a new approach to the issue of public health and Health Maintenance.

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9 A very good account of this Act exists in the book by Ruth Levitt "The Reorganised National Health Service".

10 While it is of great importance for the development of the PHIC.

The fifth section of the Act mentioned that the health authority or Board may raise money for its needs in a ‘private’ way. This may include

“public appeals or collections and competitions, entertainments, bazaars, sales of produce or other goods and other similar activities and the activities may involve the use of land, premises or other property held by or for the benefit of the health authority or Board exercising the power…” (1980, c.53, (5,1)) while similar arrangements are made a little later for Scotland as well (o.c. (5,2)).

In this Act, expenditure limits are mentioned so clearly and in such detail for the first time in the NHS history. Though their mentioning does not perform any sort of cuts in expenditure “it is the duty of every Regional Health Authority, in respect of each financial year” that the expenditure does not exceed the amounts given by the Secretary of State and any other sum of money received by them (through the aforementioned ways).

In Part II of the Act, we have the ceasing of existence of the sections of the 1977 Act (for Scotland the 1978 Act) that abolished the private pay beds in the NHS hospitals. In other words we have a first clear indication of reprivatisation of parts of the health services. It is interesting that the reintroduced pay beds were to be installed according to demand (ie according to ‘market values’) and not as in the previous legislation (1968 Act) provided that they did not disturb an egalitarian access to the service and to the ‘other’ (non paying) beds (10 and 11).

Last but not least under this new Act there was great centralisation of the Service under the Secretary of State and decrease of the power and control of the local (health) authorities. The 1984 Act introduced the Family Practitioners Committees, however, in political terms served the process of centralisation under the Secretary of State.

Last was the 1988 Act dealing with the introduction of fees for sight tests.

A general conclusion out of the changes in legislation during the Thatcherite years is that the MHM becomes if not more privatised, definitely more private-like, due to the imposition of ‘roof expenditure’, private fund raising, the change of understanding of the term ‘efficiency’ from speedy offer of welfare to ‘value for money’, and after 1989 the introduction of mangers in the NHS hospitals and of market competition in the NHS.

12 There has been one more Act of Parliament the 1990 (Chapter 19). This passed in July and is the offspring of the White Paper of 31/1/89, introducing Health Trusts, Directors etc.. Although it might be the most radical and interesting part of legislation on the MHM and the NHS it is going to be examined in a short annex of this thesis, because such a change in the way health is provided within a society, can not show its results and repercussions before some years have passed. See footnote.5 (page 25) as well.

13 “The NHS is a large and complex organisation. It needs good management. It is not a business, but it must be run in a business like way. (...). Good management is not just a matter of efficiency. We value enterprise in the public sector as much in the private sector” Conservative Party Manifesto 1987. However these post 1989 changes are out of our research focus.
that the control will be exercised by the centre under the main perspectives and parameters of efficiency and control of the cost and expenditure of the service.

**Sub-Section II**

**The financial data regarding the NHS.**

This subsection will examine the data concerning the National Health Service since 1948, or from the earliest possible date to 1989 (or to the last year available). It will approach the financial data of the NHS, or in other words, the state expenditure for a state provided Mode of Health Maintenance. In the discussion that follows the analysis of the financial data, we will examine the level of services of the NHS, in the form of the number of assets (hospital beds), and personnel (doctors, dentists, nurses and midwives). Such an examination will help answer the question of growth or shrinkage of the NHS (or in more ‘party politics’ terms the issue whether the NHS is ‘safe in the Conservative’s hands’).

**The Financial Indicators.**

After examining the legal system and framework under which the NHS and the PHIC have been operating since 1948, in this subsection we will examine the financial history of the NHS. Is the NHS starved of resources, while the needs are increasing? While the changes in the legal system and framework have not been great, is it that the financial support offered by the National Exchequer to the NHS is such that despite the formal appearance the NHS can not provide adequate health maintenance due to a lack of funding? Throughout these subsections there will be a wide use of tables about health expenditure. A close approach to the tables, their objectives, and weaknesses (and ways to overcome these weaknesses) is necessary.

There will be six tables examining the expenditure on the NHS. The first will examine "expenditure in current prices per year"; the second "rate of change of expenditure at current prices per year"; the third "expenditure in standard prices per year"; the fourth "rate of change of expenditure in standard prices per year"; the fifth "health expenditure as a percentage of the GNP"; and the sixth "health expenditure per head over the years". Each table will be in three (or -when necessary for detailed approach- four) ‘parts’, the first showing the overall performance of the particular indicator since 1948, the second its performance from 1948 to 1970, and the third from 1970 to 1989, while in the cases of very important data there will be a fourth ‘part’ for the period of 1979-89 in order to examine the policies of the Thatcher Conservative governments. Thus, (a) will indicate that the table covers the whole period, (b) 1948-70, (c) 70-89 and (d) 79-89\textsuperscript{14}.

\textsuperscript{14} This stands for the ‘Level of Services’ subsection as well.
(a) "Health expenditure at Current Prices"
This table will show the amount of money spent each year for financing the National Health Service. It is a good but not adequate indicator, since the factors of inflation and allocation of resources are not taken into account. This means that there can be higher expenditure which will not necessarily lead to better services. Examples of such cases can be the spending for equipment while there is a greater need of manpower, or an increase in the spending for wages of the personnel, without an increase of the personnel itself. This can lead to doctors and nurses working overtime and being inefficient due to fatigue\(^\text{15}\). Another distinction that should be made is that whether there is some indication about the allocation given (eg ‘patients’ no indication is given about the age and productive capacity of these patients). The Thesis is not interested in whether doctors and nurses are paid better, or whether the elderly are treated in high quality geriatric hospitals, but whether the NHS can provide a good level of maintenance of the productive capacity of the workforce. However, we include these data because they provide an initial indicatory view of the developments in health care, and because these data have been widely used for party political reasons\(^\text{16}\) despite their inadequacy. We will first approach the figures on expenditure in current prices themselves, and then the rate of change of this expenditure.

\[^{15}\] See eg. Geraldine Bedell (interview with Dr. Paul Docherty, junior geriatrics doctor at Wharferdale General Hospital, West Yorkshire) "Sick and Tired with Lives in their Hands" Independent on Sunday 14 October 1990, describing a work of 83 up to 134 hours per week, including sleepless nights followed by working mornings and failure to answer to emergency calls while in hospital and asleep.

A) Expenditure in current prices.

TABLE A: NATIONAL HEALTH SERVICE EXPENDITURE IN CURRENT PRICES.

(a)

SOURCE: 'National Income and Expenditure' and 'National Accounts' CSO London relevant years.
NOTES ON TABLE 1a) Data on expenditure for the years 1948-1951 inclusive are estimates, since such data do not exist in the 'National Accounts'7. For this period the 'NA' data mention combined expenditure on health and education. The estimates consist of:

- a) Income of employees for health and education divided by 1.905 (average rate for the next four years), plus
- b) 'Current expenditure for good and services health', plus
- c) 'Current grants to persons', a) National insurance: 1) Health.

7 Mentioning of total NHS spending starts at 1952.
(B ) Rate of change of expenditure for current prices.

This table will examine the rate of change of current expenditure for the NHS over the years. For each year the base will be the prior one and the rate will be calculated by the difference of current expenditure for the later year less the expenditure for the prior to the expenditure of the prior. Eg, for the years 1946 and 1945 it is going to be : (expenditure 1946 - expenditure 1945) / expenditure 1945 = rate of change, multiplied by 100 to give us the percentage rate. In this case as well, the problem of the impact of inflation and the pressure for higher spending that can cause will not be examined.
(B) THE RATE OF CHANGE OF NHS EXPENDITURE AT CURRENT PRICES. 

(a) 

RATE OF CHANGE (PERCENTAGES) 
OF NHS EXPENDITURE IN CURRENT PRICES, 
1949 (-48) TO 1989 (-88) 


(b) 

RATE OF CHANGE (PERCENTAGES) 
NHS EXPENDITURE CURRENT PRICES 
1970 (-69) TO 1989 (-88) 


Analysis of the graphics 
There was continuous increase in the expenditure for the NHS in current prices. Steep increase can be observed (see graph) in the mid sixties under the Wilson government and in

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Of course the problems of Table 1(a) and (b) for the period 1948-51 remain in this table as well.
the mid to late seventies, viz during the years of economic and fiscal crisis and the adoption of the IMF loan (1976). This can raise questions about the peculiarity of the NHS as a social service and as a state function, especially if we consider that it was in the mid sixties that the Wilson government abandoned the policies of full employment (another pillar of the KWS)19. Of course, the examination of simply the current expenditure over so many years cannot give a clear picture of the developments in the public health expenditure.

During the 1980s, we can observe the highest expenditure in current prices all over the NHS history. This may be a surprise, since Mrs. Thatcher was committed to lower spending as early as 1975, and the New Right ideology examined in a previous section of this chapter is very much against the provision of such ‘social goods’20.

As far as the rate of change is under question, the record high change is for the 1952 (in comparison to 1951) expenditure change. Obviously such a high change should not be taken for granted, but has to be seen in accordance to the problems of data collection for these tables. On the other hand it is contrary to the point Wicks makes that the construction of the welfare state in Britain ended in 195121. In the mid sixties there was sustained growth of expenditure in current prices, which ended up in one of the lowest increases ever in 1969 under a Labour government. Among the years easier to examine, the highest one is 1975, scoring a 33.39% increase in comparison to the previous year. Moreover, the years that follow (especially after 1976) the rate of change is higher than most of the previous years (apart of the early seventies). It should be born in mind that these are the years of the world oil crisis, and of the adoption of the IMF loan, which had restrictive influence over welfare spending. On the other hand though, these were years of high inflation, which can show a great increase in current prices spending, without achieving any great increase in real spending.

The 1980 rate of change is one of the highest ever in the NHS history, despite that it is the first (full) year of the Thatcher government. This change could be explained by the fact that this is a period of very high inflation (about 20%). After 1981 the band in which the rate of

19 See Gamble 1979, p. 53. Thus the welfare state and the relevant functions cannot be seen as a rock solid and part and parcel subject. Each sector of the welfare state (or indeed of any of the state’s functions and policies), has to be examined in its individual capacity and importance for the process of reproduction, integration, legitimation or whatever. This Thesis would never suggest a ‘ceteris paribus’ approach to politics and to state policies. The main suggestion is that great ‘group constructions’, which overlook differences, can be as misleading as single approaches, which neglect the other aspects of politics.

20 On the other hand though, this could prove the sensitivity of the NHS and its potential invulnerability due to its importance as a factor of legitimacy as the quotation by the Conservative Party (mainly if not exclusively) of data on expenditure in current prices indicates. Such an importance has been acknowledged by the New Right theoretician F. Hayek as well. See our discussion of the New Right ideology in Chapter 2 of Part I.

21 While Jessop suggests 1948, see Part I Chapter 2 dealing with the Construction of the British Keynesian Welfare State.
change moves is quite narrow, while the 1982 change is the record low for the Thatcher years, and a low change in general, if we compare it to the low of the post war period. An overall examination of the Thatcher period shows that the rate of change is lower than that of the previous years, especially of the mid sixties and afterwards. Concluding on the tables on expenditure in current prices, we would like to suggest that there has being an increase in health spending in current prices under the Thatcher governments (caused by increased needs and fears of potential political embarrassment) but the increase was not as steep as in the previous decade. Moreover, the Thatcher governments in their rhetoric and boasting have been proud of increasing the pay of the NHS staff, while the numbers of personnel has not changed significantly (see next subsection). However, the main deficiency of the data on current prices expenditure is that they do not take any account of the issue of inflation. Thus there is a need to examine other indicators as the rate of growth, the expenditure in standard prices etc. This task is undertaken by the tables and graphs that follow later in this chapter. The problems caused by the analysis of current expenditure can be solved with an approach of the expenditure according to standard prices.

(b) Expenditure in standard prices per year.

Such an approach will show the “real” expenditure for the NHS. It will be easier to compare between years, since the amounts allocated for the NHS have been calculated after allowing for inflation. The problems remaining here are that the standard prices change every 10 years, so the comparison between different decades will be impossible, and that yet again nothing is mentioned about the allocation of these resources in the NHS. Again, we will firstly examine the figures themselves and then we calculate the rate of change.
A) EXPENDITURE AT STANDARD PRICES

(a) NATIONAL HEALTH SERVICE, EXPENDITURE IN STANDARD PRICES: 1948-89


(b) NATIONAL HEALTH SERVICE EXPENDITURE IN STANDARD PRICES: 1948-70

NATIONAL HEALTH SERVICE EXPENDITURE IN STANDARD PRICES: 1970-89

**NHS Exp. 1970 Stand. Prices**

**1980 Stand. Prices**

**1985 Stand. Prices**

**SOURCE:** 'National Income and Expenditure' and 'National Accounts' CSO London relevant years.

(d/Thatcher period)

NHS EXPENDITURE AT 1985 STANDARD PRICES
THATCHERITE PERIOD

**EXPEND. 1985 STAND. PR.**

**SOURCE:** 'National Income and Expenditure' and 'National Accounts' CSO London relevant years.
The rate of change of expenditure at standard prices
The comparison will be as in table 2, but this time the prices are going to be standard. Thus, the problem of the impact of inflation over the spending itself will be solved, while the problem of the allocation of the resources remains. Last but not least, there has to be examined whether this rate of change is more than 1% which is the necessary rate of change for maintaining the level of services to the elderly standard\textsuperscript{22}.

\textbf{SOURCE:} 'National Income and Expenditure' and 'National Accounts' CSO London relevant years.

\textsuperscript{22} See Chapter I-section on financial data- of this Part on the need of higher spending for the elderly.
RATE OF CHANGE OF NHS EXPENDITURE
IN CURRENT PRICES 1949 (-48) TO 1970 (-69)

SOURCE: 'National Income and Expenditure' and 'National Accounts' CSO London relevant years.

RATE OF CHANGE OF
NHS EXPENDITURE IN STANDARD PRICES
1970 (-69) TO 1989 (-88)

SOURCE: 'National Income and Expenditure' and 'National Accounts' CSO London relevant years.
(d/Thatcher period)

Analysis of tables

Year 1952 offers a sharp contradiction to the assumptions made by studying the previous table. There was sustained growth up to then, and 1952 shows a relative decline. This can be explained though through the issue that the data of the previous tables up to 1951 were estimates. After this year there is growth up to 1960. Expenditure between 1948 and 59 has more than doubled in real terms (ie after allowing for inflation). For the whole period the change is 109.29% or an average of 9.10%, which is much higher the requirement for the elderly in the eighties (1%) as mentioned by C. Ham, and by the House of Commons Social Services Committee after the information given by Mr. B. Hayhoe (Minister of State for the DHSS)\(^23\) while we should consider that his requirement could had been even lower due to the smaller number of elderly in that period. Even if we approach the 1952\(^24\) to 1960 period the average growth of expenditure in real prices is 2.95%, which is not as impressive as the 9.10% but remains a high one. This sustained growth of the NHS has been achieved under governments of both parties, the Tories being under MacMillan\(^25\).

These years are mentioned as the years of consensus politics and butskellism, both parties were committed to the growth of the welfare state, unemployment was low etc. These were also years of low inflation and relative growth of the economy.

\(^{23}\) House of Commons Social Services Committee, HC 264-I Febbruary 1988. See our treatment of the issue of cost of health care for the aged at Part I, Chapter 3 for more details.

\(^{24}\) 1952 is a year of ‘data importance’. It is a year of decline in expenditure in real prices and the first year the NHS expenditure is mentioned as such in the CSO records.

\(^{25}\) Who became one of the fiercest critics of Mrs. Thatcher’s policies.
For the 1960 to 75 period one can observe a sustained growth (apart of the 1969 hiccup). In the decade between 1960 and 1970 (which includes the ‘bad’ 1969 year) the growth was of 30.9% an average of 3.09% per year, which is a bit higher than the one of the previous period (2.95% see table 3a) and can be generally considered as high. The 1970-75 period shows even more impressive rates of change of expenditure. In these five years, expenditure in standard prices, increased by 20.65% an average of 4.13% per year, which is the highest ever for the NHS. The years after 1973 in particular show a very rapid growth while they are in the midst of the first world oil crisis, which caused a great deal of financial and fiscal problems to all western countries. Generally, the overall growth is 57.98% for all fifteen years, which means an average of 3.86% per year. Such a growth has to be considered as a rapid one, while it has to be compared to the growing health needs of the society, especially (for the requirements of the Thesis) to the needs of the working age population.

There was sustained growth in the 1974-80 period even after the 1976 IMF loan. It is obvious that the then Labour government decided to direct the cuts to other sectors of the welfare state and not to the politically sensitive and ‘untouchable’ NHS. 1982 is the first time after the 1969 ‘hiccup’ showing cuts in expenditure. Expenditure during these years was at its highest level yet, but needs were high as well, while growth itself is rather slow. For the 1974-80 period the total growth was 22.02% which an average of 3.67% per year, smaller than the average of the previous years, but in the midst of the oil crisis, recession and IMF intervention. The records of the Conservative government are even lower. The total growth for the 1980-89 period is just over 10.36%, an average of 1.15% per year, the record low for such a long period as a decade. Moreover, it should be born in mind that these tough budgets were made some good period after the peak of the world crisis. From our point of view, such a decision should be seen in relation to the Neo Tory ideology, and the desire to reduce taxation in order to help capital accumulation.

As for the rate of change of expenditure in current prices, in the first two years of its life the NHS had a high rate of growth, which was declining. The third year though shows its minimum positive growth and the forth one (1952) is negative. This is the last of the construction period as well. The rate of growth is quite high and relatively stable for the rest of the period, up to 1960. Each year indicates a rate of growth of more than 2-2.5%. The growth itself is matching the rate of growth of the economy for these years.

While for the 1960-75 period the data show a low rate of growth in the early 60s followed by a quite high one in the mid and late sixties, relatively higher than the one in the previous period. The decline of 1969 is followed by high growth while in the midst of the oil crisis the rate of growth is very small (1974: 1.28%), but not in the very next year which performs the highest change for the whole post war period 9.12%. A general conclusion
from a first observation is that there is higher growth than in the previous period, but this growth is very unstable, the band ranging from -1.12% to 9.12%.

For the Labour government (mid seventies) period the growth is at the level of the first period of the NHS, while in 1982 we observe negative growth once again. After 1982 the rate of growth is the slowest ever observed in the whole history of the NHS, 1989 been the minimum ever (0.10%). As the growing needs of the elderly, the victims of AIDS (and the research for this disease), and the ever growing costs of the medical technology are taken under consideration, the increase seems minimal. Moreover, the Thatcher governments have been proud of increasing the pay of the NHS personnel (especially the wages of the nurses), without increasing their number. Concluding on matters of real expenditure for the NHS, it is obvious that the NHS has been shrinking under Thatcherism in comparison to the growing needs of society.

As for the per head expenditure for the NHS in standard prices is given by health expenditure of each year when divided by the population of Britain (for that year). Thus, an examination of the ‘health wage’ would be possible, and the approach of the question higher or lower spending would be partly achieved. Of course a major problem for analysing the allocation of these resources, is the age profile of society, the change of cost of the medical technological equipment and of course the great problems of age and AIDS and the fact that increased spending can be a response to Union pressures in the form of wage settlements with the personnel of the NHS.

These tables have not been included to the Thesis as their performance is about identical to this of ‘Health Expenditure in Standard Prices’, with rapid growth in the mid fifties and sixties, (interruption in 1969) and cuts in 1982 etc. As for the rates of change, there is no analysis. The curve is about identical to the curve for ‘Rate of Change of NHS expenditure in standard prices’. We believe that any further treatment of the data would make our data collection repetitive.

(c): **Health expenditure as percentage of the Gross National Product.**

This is a very clear indicator of expenditure and especially of the willingness of a government to spend on health. It may be the indicator that is statistically clearest, but a decline in the rate might not necessarily mean a decline in expenditure. It can be caused by a growth of the GNP, not followed by an analogous growth of spending for health. Moreover, it does not mean a decline in the level of the services offered, as the health maintenance needs of the population can remain relatively standard (in comparison to the

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26. See next section ‘Level of Services’.
27. Or if it is not a general census year by the estimated one by the Central Statistical Office.
28. Term coined for the purposes of the Thesis, it is coined after the term ‘social wage’
growth of the GNP). The opposite may also happen; an increase in the share of the NHS expenditure which is inadequate to cover the health needs of the population29.

NHS EXPENDITURE AS PERCENTAGE OF THE GROSS NATIONAL PRODUCT.

(a)

![Graph showing NHS expenditure as percentage of the GNP from 1948 to 1989.]

SOURCE: 'National Income and Expenditure' and 'National Accounts' CSO London relevant years.

29 While Mick Carpenter in his 'Left Orthodoxy and the Politics of Health' (in Capital and Class 11, Summer 1980), takes a critical view to the simple and single 'anti-cuts' approach and suggests combating the causes of ill health in capitalist society.
NHS EXPENDITURE AS % OF GNP
1948-70

NHS EXPENDITURE AS % OF GNP
1970-89

SOURCE: 'National Income and Expenditure' and 'National Accounts' CSO London relevant years.
Analysis of Graphs.

The share of the GNP allocated for the NHS expenditure in the 1948-53 period was small but growing. In general, there had been growth in the share of expenditure which can be explained both by the increase of needs and the political importance of the issue. The record high share in the GNP is in the 1976 budget; the very year of acceptance the IMF loan was accepted. Of course it can be claimed that the budget was planned in 1975, but the 1977 share is high as well, while in late seventies there is a relative decline since the share of the NHS expenditure in the GNP, as it goes back to early seventies levels. In general, for the whole post war (pre Thatcher) period the share of NHS expenditure in the GNP has been growing.

The average expenditure for the NHS is a little higher than that of the previous periods (apart from the mid seventies) but getting lower. But exactly since the expenditure during the late seventies was shaped under the conditions of the IMF loan and the second oil crisis, and the rate had been growing up to the mid seventies, the relative decline might mean shrinkage of expenditure. In general the NHS share in the GNP is high but not as high as in previous periods. And once again when the new increased needs of the elderly, the AIDS victims, infants etc. are taken under consideration, then there are indicators of a shrinking NHS expenditure.

General -interim- Conclusion on the Financial Indicators.

The NHS never faced any period of great financial growth. It was a just slowly growing service, and there was some increase of its pace of growth in spells in the sixties and especially in the mid seventies. **During the years of the Thatcher governments the finance of the NHS has been clearly shrinking in relative terms.** The 1982 incident suggests that an attempt to ‘dwarf’ NHS was made, but had no continuation. We think that we can conclude that the NHS has been shrinking (financially) in comparison to its potential needs and requirements during Thatcherism. While C. Ham claims that the minimum increase necessary in real prices has to be 1% per year just to

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30 This is the very reason of having many tables. The subject can be examined by a variety of viewpoints and a better understanding of the developments can be achieved.

31 This is not absolutely necessary; it might be that the nation is wealthier, the GNP so much higher that the share of the NHS can decline, without affecting the services. However, the GNP has not grown that much!

32 Possibly for ideological reasons and for reducing taxation, since the peak of the world crisis and of the British crisis had passed.

33 Such an attempt could had been very costly in political terms. These are years of high unemployment, the popularity of the government was at record low, and increased after (or even due to) the Falklands’ war.
cover the needs of the elderly\textsuperscript{34}, we should add the rising cost of medical technology, AIDS treatment, salaries etc.; the average increase in the Thatcher decade has been 1.11%. It is obvious that the years of an 'ample' Butskellite expenditure have ceased, and that the predominant policy between 1979 and 1989 was one of monetarist expenditure control\textsuperscript{35}. All these statistical and financial indicators can be misleading since (as mentioned earlier) the allocation of these resources has not been examined (and can not be examined properly for the purposes of the Thesis). As the age profile of society changes every year, (due to the extension of the length of life), there should be changes in the patterns of spending and on spending itself in order to keep pace with these changes. One way of combating this problem is by the application of these statistics to the NHS itself and by the examination of the NHS personnel and equipment. Thus, the next sub-section will concentrate on the level of services of the NHS as can be anticipated by an approach to its equipment (hospital beds) and personnel (doctors and dentists, and nurses and midwives).

\textbf{Sub-Section III}

\textbf{The level of facilities and personnel in the NHS}

Having examined the ‘financial history’ of the NHS, in the previous subsection, we now are going to approach the data about the level of facilities in the NHS. It is not only the money allocated that determines the level of health provided, but the equipment and human resources which will be employed by this money in the process of health provision. Thus we are going to examine a number of key\textsuperscript{36} parameters of the NHS. There will be tables examining the number of beds in the NHS hospitals (and the rate of change of this number over the years), the number of doctors (and the rate\textsuperscript{37} of change of the number of doctors over the years), and the number of nurses and midwives (and the rate of change of this number over the years), in order to help us assess the potential of health provision through the NHS.

(a) The number of the NHS hospital beds.

The in-patients are a large number of the NHS users. Whether they are admitted for treatment or surgery, they use the hospital’s beds. The number of hospital beds can be seen as one of the indicators of the ‘magnitude’ of a health system. There will be two tables; (as usual in this Thesis) one for the post war period and another for the Thatcherite one.

\textsuperscript{34} See our reference to the HC 264-I February 1988, earlier in this Chapter, and in Chapter 3 of Part I also.

\textsuperscript{35} The repercussions for the level of health maintenance are going to be examined in the next section. The political implications of these changes at the next Part of the Thesis ‘Conclusions’.

\textsuperscript{36} Or maybe just indicatory.

\textsuperscript{37} Rate to be calculated as in Table 2 of financial data. This stands for all rate of change calculations.
Number of National Health Service Hospital beds.

(a)

NUMBER OF NATIONAL HEALTH SERVICE HOSPITAL BEDS (thousands) 1952-89

HOSPITAL BEDS ,000S

YEAR


(b)

NUMBER OF NHS HOSPITAL BEDS (thousands) 1952-1970

NUMBER OF HOSP. BEDS

YEAR

SOURCE: Annual Abstract of Statistics CSO London, various relevant years
(c) NUMBER OF NHS HOSPITAL BEDS
1970-89

YEAR

HOSP. BEDS


300 400 500 600

SOURCE: Annual Abstract of Statistics CSO London, various relevant years

(d) NUMBER OF NHS HOSPITAL BEDS
1979-88 (Thatcherism) PERIOD

YEAR

HOSP. BEDS


360 380 400 420 440 460

SOURCE: Annual Abstract of Statistics CSO London, various relevant years

Analysis of the graphs.

During the first years of its life the NHS expanded in matters of hospital beds, achieving a maximum of 563.5 thousand in 1957. In the next 22 years though, it shows a sharp decline, ending up with almost 100 thousand beds less in 1979 than the maximum year. This is a decline of -17.72% for the whole period, or in other words of a -0.80% per year. For the whole post war period the decrease is -15.61%, an average of -0.57% per year. The decline does not perform any particular patterns, it gets much steeper after the late 1960s. It may be surprising that there is decline even during periods of high expenditure and high increase of expenditure as the mid sixties and the seventies.

The downward trend continues in the Thatcherite period. It is going even sharper, achieving a total of -17.66% (or an average of -2.20% per year) but the year of the major cuts in real finance of the NHS (1982) and its next one (the results could had appeared in the next year, since there would be a lag between change in financing and its repercussions) are contrary to the potential anticipation after reading the relevant tables, as they do not offer any great bed losses. This can confirm an explanation of the downward trends. The days of in hospital stay, have been decreasing all over these periods\textsuperscript{38}. Thus, it can be claimed that there is a smaller need of hospital beds, since each bed can be used by more people in a period of time (eg a month). In such a way the NHS can be seen as a victim of its own success. On the other hand though, the problem of the lengthening waiting lists\textsuperscript{39} should be taken into consideration, as more beds might be required for treatment. It could be also argued that most of the wards closed were geriatric ones, a fact that indicates a sharp change of policy. This question however remains outside our area of interest. All these factors make a conclusion on the issue difficult. This is why we use the data on the hospital beds more as an indicator of the ‘magnitude’ of the NHS than as a factor contributing to quick repair of the productive capacity of the workforce.

(b) Doctors and dentists.

This thesis examines the NHS as the ‘repairer’ of the health (and consequently the productive capacity) of the workforce. But it is not only the moneys allocated or the number of beds that will determine the level of health provision. Health care is another outcome of human activity, so the number of health personnel has to be examined. Doctors and dentists\textsuperscript{40} are the most specialised members of the NHS staff, and in most cases the key (or leading) figures in the process of treatment. This is why the number of doctors over the

\textsuperscript{38} See next section discussing the level of morbidity and absenteeism from the workplace.

\textsuperscript{39} See next section discussing the level of morbidity and absenteeism from the workplace.

\textsuperscript{40} These tables include all full time doctors and dentists, regardless of their position as GPs, registrars or whatever.
years must be examined\(^4\) .

NHS Doctors and Dentists.

(a)  

![Graph: Number of National Health Service Doctors and Dentists (1952-89)]

SOURCE: Annual Abstract of Statistics CSO London, various relevant years

(b)  

![Graph: National Health Service Doctors and Dentists (1952-89)]

SOURCE: Annual Abstract of Statistics CSO London, various relevant years

\(^4\)For quite the same reasons (not as the 'leading figures' though the number of nurses and midwives is going to be examined in the next table).
Analysis of the graph.

There is a continuous upward trend in the number of NHS doctors and dentists in the whole post-war period. The number of NHS doctors and dentists has almost doubled in these 27 years. There has been an increase of 38161 doctors in absolute numbers or of 88.08% in 27 years, which gives an average of 3.26% per year for the whole period. The increase is smooth up to 1960, then it performs a ‘leap’ to 1961 with 7352 new doctors. This year can be seen as a boundary for another reason as well. The increase after that is much steeper while for the last pre-Thatcherite decade the numbers are getting quite higher. There were 18201 new doctors these years; a total increase of of 31.67%, or an average of 3.51% per year.

As a conclusion to these tables it can be said that the NHS had been growing throughout its history as far as the number of doctors is concerned.

Examining the period of the main interest of this research, we see that during eight first years of the Thatcher decade the upward trend the number of NHS doctors and dentists has continued to grow, though not at the pace of the previous years. The increase is not as sharp, there is total number of 13,049 newly appointed doctors and dentists; an increase of

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42 However, as it takes some five to seven years to ‘create’ a doctor, some credit should be given to the governments’ of the mid fifties and their planning.
15.50% over this period or an average of 1.93% per year, which clearly smaller than the achievements of the previous periods. There is a slowdown in the development of the NHS as far as the number of doctors and dentists is concerned. It can not be claimed though that at this respect the NHS is being dwarfed; not even shrunk. What we do think though is that the number of NHS doctors has reached to the margin between expanding and shrinking, in real terms, since the needs and expectations are ever growing.

The rate of change of the NHS doctors and dentists

![Graph showing rate of change of National Health Service doctors and dentists, 1953(-52) to 1989(-88).](a)

 SOURCE: Annual Abstract of Statistics CSO London, various relevant years
(b) RATE OF CHANGE OF NHS DOCTORS AND DENTISTS 1953(-52) TO 1970(-69)

SOURCE: Annual Abstract of Statistics CSO London, various relevant years

(c) RATE OF CHANGE OF NHS DOCTORS AND DENTISTS 1970(-69) TO 1989(-88)

SOURCE: Annual Abstract of Statistics CSO London, various relevant years
This table follows the same trends as the previous one. The rate of change is literally well over 2% throughout the seventies. Unsurprisingly the record high year is 1961 scoring a 15.19%, little less than triple the next best performance of 5.49% in 1979. The short term slowdown in 1962-66 can be related to the financial problems the NHS faced in 1962\(^3\), but the general feeling is that 1961 acts as a stepping stone for new developments and expansion, which became much more evident in the seventies. The indications showing an end of expansion are more evident at this table. The rate of expansion is declining, rather sharply, while the increase in 1988 does not necessarily show any change in attitudes, since any more recent data were not available.

A general conclusion about the question of growth or shrinkage of the NHS as far as the aspect of new doctors and dentists is concerned, is that the NHS has been growing rather rapidly during the post war period, while Thatcherism brought an end to this growth. There are indicators of a potential decline, but the data of the observed period are too little to comment on in more detail (since they stop at 1988, which shows an increasing trend too).

\(^3\) On the other hand the 1961 increase is such that it might be that for the next few years not many new doctors were needed.
In no case can it be suggested that the NHS has been dwarfed. It might be that we are facing a beginning of shrinkage, that the boundary between expansion and shrinkage has been reached, especially if we consider the lower expenditure examined in the previous group of tables, and the potential inefficiency of doctors due to working overtime.

(c) Number of nurses and midwives
These two tables will approach the number of the other large and important group of NHS personnel, the nurses and midwives, for the same reasons as for the approach to the number of doctors.

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**NATIONAL HEALTH SERVICE, NUMBER OF NURSES AND MIDWIVES 1952-89**

![Graph](image)

**SOURCE:** Annual Abstract of Statistics CSO London, various relevant years

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**NB.** As far as numbers of doctors and dentists are under examination

**3** See footnote, mentioning hard work for junior doctors.
NHS NURSES AND MIDWIVES 1952-1970

SOURCE: Annual Abstract of Statistics CSO London, various relevant years

NHS NURSES AND MIDWIVES 1970-89

SOURCE: Annual Abstract of Statistics CSO London, various relevant years
Another aspect of the NHS indicating growth over the post war period. It is sustained but smooth (not rapid) to mid sixties when it shows an acceleration and then it faces the problems of the late sixties and 1970, which can be related to the finance problems of these years. The increase is getting sharper in the seventies while the overall examination of the post war period shows that there were 130,668 more nurses in 1979 than in 1952; a total increase of 79.30% or an average of 2.93% each year (37.82% for 1952-70 or average of 2.10% per year), while the records of the seventies decade are much better showing an increase of 68328 nurses and midwives in absolute numbers, which is a total 30.38% or an average of 3.34% each year. It is again obvious that the NHS (when examined via the aspect of nurses and midwives) had been expanding in the post war period and its pace of growth got faster in the seventies.

The Thatcherite period (up to 1987) shows both highest numbers of nurses and midwives ever and slowest growth ever. The overall increase of the number of nurses is just 27,989, a total increase of 9.15% or an average of 1.30% per year. So, once again the NHS has not been dwarfed but there are clear indications of shrinkage under Thatcherism, especially in comparison to the expanding needs.

46 Bare in mind that (as mentioned in the note of the table) 1969 is a peculiar year since only N. Ireland shows increase of nurses.
The annual rate of change of the number of NHS nurses and midwives.

(a)

![Graph showing rate of change of NHS nurses and midwives from 1953(-52) to 1988(-87)]

**SOURCE:** Annual Abstract of Statistics CSO London, various relevant years

(b)

![Graph showing rate of change of NHS nurses and midwives from 1953(-52) to 1970(-69)]

**SOURCE:** Annual Abstract of Statistics CSO London, various relevant years
(c)

RATE OF CHANGE
NHS NURSES AND MIDWIVES
1970(-69) TO 1987(-86)

(d) Thatcher period

RATE OF CHANGE OF NHS
NURSES AND MIDWIVES
1979(-78) TO 1988(-87) (Thatcher period)

SOURCE: Annual Abstract of Statistics CSO London, various relevant years
Analysis of graphs.
There had been sustained but unstable rate of growth over most of the post war period. As previously mentioned the late sixties records indicate and reflect the financial conditions of these years, while such an incident exists for the seventies (from another point though, this of increase); however, this trend is not followed in the late seventies. In general there were great ups and downs of the rate of expansion of the number of NHS nurses and midwives, while there had been an overall upward trend in the requirements of the new needs.

While the early eighties follow the trends of the pre Thatcherite period, there is spectacular decrease afterwards. There is a strong downward trend especially after 1982 (tough budget, results become evident 1983). There is very slow up to literally no change at all. If earlier years just followed the needs, then in recent ones the NHS has been dwarfed. If the NHS was expanding then, now it is just shrinking.

Conclusions on level of facilities and personnel.
A general overview of the NHS level of services shows that according to the first component (hospital beds) the NHS has been shrinking since its very first years of life, while this shrinkage has become more evident in the recent Thatcherite period. The numbers of doctors and the pace of its expansion is large after the sixties and especially during the seventies, while there is a slowdown in the years of the Thatcher government. The number of nurses has never shown such an expansion as that of doctors, while is under standstill during the last decade.

From our point of view, the NHS has entered a period of reducing its level of services in comparison to the previous periods and especially to the decade of the 1970s. These policies indicate even a possible shrinkage of the NHS in comparison to the needs it has got to combat in order to act as the provider of a healthy workforce.

Reasons for this shrinking of the NHS can be found in the -New Right- Tory ideology analysed in Chapter 2 of Part II. There is an unhidden distaste to the large ‘statist’ policies and to such conceptions as the NHS. The argument that is mostly expressed as a reasoning against such policies is that they create large bureaucracies which are detrimental to democratic freedoms. There is an anti-expenditure attitude in the New Right ideology as taxation is supposed to ‘steal’ money from profit and investment. The ‘state’ has to be diminished, so state assets and personnel have to drop as well. Thus, in accordance to the New Right Ideology, the NHS has had to shrink under the Tories and it has happened so, both in matters of beds and personnel.

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AN OVERALL CONCLUSION ON THE DEVELOPMENT OF THE NATIONAL HEALTH SERVICE.

The NHS has been an important feature of British society and politics for more than forty years now. It has faced periods of great expansion and it is now the largest single employer in the country and one of the largest in the world. Concentrating on its last twenty years we can see two totally different periods. A period of great expansion and ‘egalitarianisation’ in the seventies (beginning in the sixties) with high expenditure and high rates of expansion of expenditure, and personnel intake on the one hand, and abolition of the pay beds (1976, Barbara -now Baroness- Castle) on the other. This picture is reversed in the 1980s. The NHS is starved of resources in terms of standard prices, getting enough money just to cover the growing needs of the elderly, while expansion of the number of doctors and nurses is literally brought to a standstill even in absolute numbers. Last but not least, as early as 1980 the pay beds have been reintroduced (under market needs) the hospitals and health boards have to make their own money in the market and what is most important roof expenditure was introduced. It is clear that the rate of growth of the NHS has been dwarfed under the Tories. Thus the NHS itself has been shrinking since -as postulated in Section 1 of this chapter- a maintained MHM is one that keeps its pace of growth in accordance to the changes in society and the growing needs. So we can claim that it ‘is not safe in their hands’. This can be seen in the following table:

NHS OVERALL PERFORMANCE 1970-89

![Graph showing NHS overall performance from 1970 to 1989.](image)

---48 Term used as short for 'full time doctors and dentists and full time nurses and midwives' see relevant tables.
Equally, it has become more market-like and considerably less state funded and independently controlled. Such a development is very much in line with the New Right ideology, though it has not achieved all the ideologists of the New Right are advocating. The main question in relation to the thesis is whether these changes indicate any form of jeopardy to the process of production due to inadequate maintenance of the productive capacity of the workforce, or a transition to a ‘post fordist’ organisation of society and state, with the important ‘core workers’ been covered by the Private Health Insurance Companies. For the time being, the Thesis will concentrate on the development/growth of the PHIC since 1948 and especially under Thatcherism.

Sub-Section IV
The level of services at the NHS.
In these paragraphs we will examine the NHS ‘services’ records. Is the way the state has chosen to rectify illness adequate (and what is easier to examine statistically) is it more efficient than it used to be in the previous years?
We will concentrate on two different indicators that can show the increase or decrease in the records of the NHS and also the potential cause of problems in the process of production, due to worsening in the NHS records. These two are:
a) The length of the waiting lists, since some people whilst they are in the waiting list cannot either perform to their productive capacity at all, or at best to a reduced level. Additionally, the longer the waiting lists are the more inefficient the MHM is considered to be. And
b) The duration of the in-hospital stay. It is important because while somebody is in hospital (s)he cannot be at work. Of course, ‘out of hospital’ does not mean at work. There are cases either of home treatment or of home post surgical rest, which some years ago might have had to be days of ‘in hospital’ treatment. Despite these difficulties we think that this is another important indicator.
The only problem (as we mentioned earlier) is the lack of any social or skill classification.

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49 Question to be approached in the next section discussing ‘The Achievements of the NHS in the Process of Health Maintenance.’.
50 Question to be approached at the next Chapter 2 discussing issues about the PHIC.
51 The way itself remains mainly the same in statutory terms. We should however consider the changes in terms of its functions and spending.
52 See previous chapter and introduction of this one.
(a) The waiting lists.
We are going to have two different tables, one for the pre Thatcherite and one for the Thatcherite period. Are the waiting lists getting longer or shorter over these years?

![Graph 1](image1)

![Graph 2](image2)

**SOURCE:** 'Social Trends' various relevant years

**Analysis of trends in the Waiting Lists.**
a) We will start by examining the waiting lists of the pre-Thatcherite period. Initially they were low but we have a rise after 1971. What is interesting is that every couple of years the figure remains rather stable (but we note however an increase in 1979), while for the years 1977-78 which are the two years with the most significant numerical (upwards) change the rate for surgical in patients is larger than this one for 'general' (or 'other') in-patients
(12.42% to 5.4%), while the overall rate of change is 10.73%; this is a quite high rate. Thus, the waiting lists in the pre-Thatcherite period were rapidly reaching new highs, and that there was a potential threat to production (if we assume that while someone is on the waiting list his/her 'productive' activity is restricted).

b) In this second concluding paragraph we will concentrate on the achievements of the Thatcher governments as far as the waiting lists are concerned. The first years of the Thatcher governments had been very successful. There was a great downward trend and 1981 was the year with the shortest waiting lists since 1977. This was mainly for surgical patients with the trends being slightly different for the 'others'. It seems that it was easy to be admitted to hospital, at least that it was easier than it had been by the end of the previous decade. But we face a greatly stable. Later the numbers will begin a downward trend again but they never get to 1981 level, because of the upsurge two years later. We would like to argue that the 1982 increase should be related to the cuts in real funding for the NHS for that year by about 0.74% (at 1985 standard prices), and that it indicates the sensitivity of the NHS as a system and the close relation between funding and results. The third peak year is 1986 and after that there is relative stability coupled with a slight downward trend. We regard such waiting lists as very large, and consequently that the MHM is not doing well in general. As we have earlier there is not any reference to social class or occupation of the people who are on the waiting list. So, we can not comment with any certainly on issues of problems in production; considering the data in the Black Report and the other evidence in this chapter we can assume that a large number of working class people are on the waiting lists. It is unknown whether being on the waiting list coincides with restricted activity. Thus it is difficult to say whether (as far the waiting lists records are under question) the MHM is working well or not, according to our approach and research. But in any case we assume that even a minute number complies with our point. In any case the difference between 1966 (604 thousand) and 1987 (805 thousand) is a large one. The two main leaps in the waiting lists were the differences between 1977-78 and 1981-82. We think that there is not much room for optimism as the numbers of people on the waiting lists are already large and we do not foresee any great reductions. In this sense the MHM needs improvements.

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82 Again this is an indication of performance by itself (see our analysis about 1982) and a potential cause of problems for production if there is a coincidence of 'being in the waiting list' and 'being unable to work'. However there is not any clear statistical reference to such a coincidence. In short, though we do not absolutely exclude the possibility of such a case, the waiting lists data are included mainly as a scrutiny of the performance of the NHS and less in a close relation to our theoretical hypothesis.
(b) In hospital stay.
Again we are going to work on two periods/tables. We will examine the trends both in each period both individually and in comparison with the other.

(a)

![Graph of Duration of Hospital Stay for NHS Patients]

**DURATION OF IN HOSPITAL STAY (DAYS) FOR NHS IN PATIENTS 1966, 1971 and 1976 to 1986**

**YEAR**

**DAYS**

- **GENERAL MEI**
- **SURGERY**
- **MATERNITIES**

**SOURCE:** 'Social Trends' various relevant years

The in hospital stays are long throughout this period. Especially the 1966 records are very high. We should also take consideration of 'out of hospital' health factors. Eradication of some diseases has contributed greatly to the reduction average length of in hospital stay in two ways: a) less people are infected by the disease, so there are less admissions to hospital, and b) some diseases needed lengthy treatment, but now that they have been eradicated the very reason of long stay in hospital is gone. In any case, the 1966 records are high and they might have created problems in production due to long and continuous absenteeism.

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In this case the length of in-hospital stay is also decreasing over this time. At the end of the period (of the data available) in-hospital treatment is very short indeed. The only indicator that could be considered as getting worse is the rate of decrease, but we think this could be due to examinations being lengthy for technological, medical and chemical reasons (or due to the need of double check -at intervals of 12 or 24 hours). So, a minimum stay in hospital is from our point of view inevitable and unavoidable. And the closer you get to this minimum the lower your rate of decreasing the in hospital stay becomes.

In any case, what is most interesting is the shortness of duration of in-hospital stays which is much lower than it used to be in the mid sixties (18.6 days to 8.6 for medical treatment, 10.7 to 6.5 for surgical, and 8.1 to 4.5 for maternities)

To this we have to add the increase of life expectancy from the sixties to today, and the lower infant and perinatal mortality rate. So in this respect (and as far as the reproduction and the maintenance of the productive capacity of the workforce is concerned) the British Mode of Health Maintenance -viz the NHS has been successful).
SECTION 2:
"THE ACHIEVEMENTS OF THE NHS IN THE PROCESS OF
HEALTH MAINTENANCE."

This section will examine the results and repercussions of the changes in the Mode of Health Maintenance, as far as the productive capacity of the workforce is concerned. In other words it will approach the question of 'jeopardy of production' (or maybe of 'non improvement of productivity' if we accept that rates in the previous years were not good either), or of overcoming these problems. Thus, it will help us examine our theoretical hypothesis of Part I.

The section is divided into three subsections. The first one, deals with the cost of absence not from a 'theoretical/Marxist' point of view as our hypothesis is, but from an 'applied/managerial' one, as most of the sources for it come from the employers' side. Subsection three is the key empirical one, as it deals with the question of the level of health of the British people, the achievements of the MHM and their 'results' viz. the absence from the workplace. Thus, subsection three is divided into two respective paragraphs. The first one analyses the issue of 'illness', the second the NHS and the third the 'results' as far as absence from the workplace is concerned. The illness subsection will first deal with the chronic illness (for the years 1980-86) and second with the acute (1973-75 and 80-86). For each 'illness' there are four tables, the first for the 'Intermediate and Junior non Manual', the second for 'Skilled Manual and Own Account non Professional', the third for 'Semi Skilled Manual and Personal Service' and the fourth for 'Unskilled Manual'. After the display of the health records themselves there is an investigation of the rate of change of the level of acute illness. Last in this section there is a comparison between the 1973-75 period and the 1980-86. The second will discuss the 'results' of the 'efforts' of the 'repairer' (which was approached in section 1) to tackle the problems mentioned in the first. It will deal with absence from the workplace (due to health reasons) from the statistical year 1962-62 to 1987-88. There are three tables in this paragraph one for the whole period, one for 1962-63 to 78-79 and one for 76-77 to 87-88. This overlapping being deliberate since it can show trends between the pre-Thatcher period and the Thatcher one.

Finally, there are some 'Conclusions' which deal with the issues of absence and restricted activity, absence rates and NHS records and a total recapitulation of the chapter as 'general conclusions' dealing with the question of potential jeopardy of production.

For the subsection about the managerial approach to absence we have mainly worked with editions of the 'Employment Gazette' (Published by Her Majesty's Stationery Office) and

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4 See Part III of the Thesis "Conclusions".

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books, publications and personal communications with the Confederation of British Industry and the British Institute of Management. The sources for the ‘statistical, absence’ section were the ‘General Household Survey’ the ‘Social Trends’ and the ‘Social Security Statistics’, all being publications of HMSO.

From our point of view this is a key section for the whole project, as in it we will examine our theoretical framework through some empirical data and some “managerial” approaches to the issues. We hope that these data and approaches will support if not the validity of our theoretical framework at least the importance of our approach and research project.

“Every year in Britain 300 million working days are lost through absence due to ill health; which means that in addition to the time accounted for holidays, contractual leave, industrial dispute and jury service, roughly two more working weeks are lost due to illness for each member of the working population.” (Roger Steel 1988), while later on in his article55 he indicates the influence of job satisfaction and other personal reasons as far as presence of the worker at the workplace is concerned.

For the time being though, we will concentrate on some methodological terms and issues/problems relevant to this section.

As mentioned in the introduction and in Chapter 3 of Part I, there are a variety of problems involved in the selection and classification of data. Restricted activity does not in all cases coincide with absence from the workplace, as the restriction might concern activities of leisure time. That is why we try to cross check the data and incorporate data about absenteeism (collected by the Department of Trade and Industry and the Confederation of British Industry). We must always bare in mind however that absenteeism due to ‘health reasons’ also has to be related to a number of other “human” factors, which might be (and indeed are) invisible in statistics such as job satisfaction, danger of facing the sack, organisation of the work of the GP etc.56. Last but not least these data can never be “pure”. The level of health in a society is not influenced only by the way health is maintained in it. Other determining factors can be nutrition, smoking and exercise habits, pollution, housing conditions etc. So, all these statistical data have to be taken “cum grano salis”. We hope though that by this “cross check” of the various data and sources we will be able to avoid grave mistakes, as long as we are aware of the dangers, limitations and incompatibilities of the existing data with one another and with aspects of our arguments.

55 “Situations People Face and Fudge” in Employment Gazette 1988 pp. 390 ff. The article itself concentrates on issues of dismissal due to high absenteeism.

56 For a more detailed analysis and discussion see Part I, Chapter 3.
Sub-Section 1:
The cost of absence.
Every year an average of between 212.8 and 284.6 million days are lost due to certified illness whereas if we take into account the non certified as well, they can be over 300 million working days lost. In 1979 (which was the year of the greatest industrial unrest in contemporary British political history -1983 scoring a little lower-) there were more working days lost due to ill health than due to industrial action! “Over four million working days were lost certified illness in 1979’ Mr. Keith Chadwick....‘but I wouldn’t mind betting that the true figure is at least 80% up’ added Mr. Chadwick” (Employment Gazette 1982 p.85). The numbers according to other approaches are 243.6 million days due to ill health, to 29,474 thousand days due to industrial action57; and if we consider the cases of uncertified illness, we have a total of 371 million58. According to a survey by the British Institute of Management “on average more than a million people are absent from work in Great Britain every day. This represents 5 per cent of the labour force” (BIM 1961 p. XI). More recently (February 1989), John Banham. (Director General of the CBI) introducing “Managing for Attendance” (CBI edition) mentioned that

“Employees who fail to turn up for work probably cost the economy over £5 billion a year. These costs, imposed by absence and the consequent disruption, are a serious handicap to our competitive success - they represent around one third of our total annual investment in skill training for instance. For every working day lost through strikes, more than 30 days are lost through absence59.” (J. Banham, in CBI ‘Managing for Attendance’ Feb. 1989, page 5.)

As we mentioned earlier in our introduction to this part of the Thesis, absenteeism can be expensive for industry. In this chapter we will try to examine this issue in a little more detail.

According to the British Institute of Management

“...Oswald Moor states ‘as far as it can be computed, the average rate of preventable and


58 See Social Security Statistics; these data are going to be approached in more detail in the next subsection

59 Health is not the only reason for absence. CBI in this (Feb. 1989) document (page 11, Table 1), suggest (and classify) a variety of “Reasons for not being at work: Absence due to company policy, eg: holidays, training courses, study leave, union activities, civic duties, short time working maternity leave paternity leave unpaid leave of absence; Statutorily defined absence eg: attendance at courts of law, civic duties, union activities; Group absence eg: internal disputes, external disputes; Absence by individuals with prior company authorisation, eg: visits to doctor, without prior company authorisation, eg: sickness, injuries default.” (Bold type and underlining in original). The thesis is interested exclusively in the cases of visits to doctor and sickness as the rest fall beyond the realm of the NHS.
inexcusable absence in British factories is at present between 2% and 3% of the manhours worked’. He goes on to estimate that if this 2% or 3% were not lost, we could produce an extra £200,000,000 to £300,000,000 a year in goods and services.” (BIM 1961),

This cost can be analysed to variable and fixed costs60. This though does not mean that the figures are easily comparable. Absence of a small number of people from the workplace constantly creates less problems than absence of all at once (strike).

As for the health related reasons, there was a change to self certification of incapacity to work in 1982. GP’s certification was no longer necessary for cases of illness lasting less than one week. This created anxiety about a potential increase in the days of absence (Empl. Gaz. 1982 p. 249), but this anxiety was not justified by any serious change in the years that followed (Edwards and Widston 1989 p.1). While in the survey by the British Institute of Management (1961) it is estimated that the cost per person may vary according to firm form as low as £1 1s to as high as £7 5s per employee over three months (ibid p. 28 NB monetary change in 1971).

Another similar case of high cost for the industry is discussed in the Employment Gazette of 1975 (p. 19). For the then Director of the Health and Safety Executive, Mr. John Locke (and according to information given by the Engineering Employers Federation), it was clear that the cost of accidents in terms of loss of labour and its effects on production “is very substantial” and that expenditure in safety could reduce the cost of lost production. Though the cases are not identical (in this case J. Locke refers to the prevention of accidents while we are examining the ‘repair’ of the sufferer -more importantly not only of the accident sufferer-) we think that this issue is important for our Thesis.

More recently (CBI 1989) the cost of absence has been estimated to £5,000 million a year. This is based on a CBI survey of 431 companies employing more than 1,200,000 people showing (among other things) that manual workers have a higher rate of absenteeism than non manual mentioning other reasons than health also. Another study points out that “absence rates had not gone down over the last five years”. Despite the fact that all these estimations are very subjective (they have even been called ‘guesstimations’) “it is true that absence is a salient issue for many employers” (Edwards and Widston 1989 p. 1). Or as Patrick Nichols62 said “A good health and safety record is a sign of good management. Accidents and ill health cost money and mean ruined lives, lost production and inferior products”, and he later mentioned the need of inspection programmes in high risk areas63.

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60 This is in 1961 prices; not in 1992 ones.
61 See introduction to this chapter and Employment Gazette 1988 p.390.
62 Minister of State for the Department of Employment.
From our point of view this is only one side of the coin. Absence from the workplace for health reasons is not only caused by industrial disease or industrial accident. This is why we have examined the ‘rectifier’ earlier in this chapter. The importance of the NHS is crucial at this point. Health care can be very expensive and it is not certain that it will give great profits to the individual capitalist. As we have concluded in the first Part of this Thesis there is a need of an agent who will be outside and alongside society to undertake its reproduction.

What we are going to examine in the remaining part of this chapter, are the records of ‘achievements’ of the MfM (mainly the NHS) in maintaining the productive capacity of the workforce by keeping it healthy, or by ‘repairing’ it (curing in medical terms) quickly. In the pursuit of this question we will examine the records of restricted activity for health reasons (both long standing and acute illness) and the records about absence from the workplace for health reasons.

Sub-Section II: Restricted activity: the 1979-89 records.

In this section we will examine the health and records for the years between 1979 and 1989. We are going to examine how restricted activity can be caused either by long standing (or chronic illness) or by acute illness. In both cases it is not clear whether the restriction concerns leisure or working time, but in either case it is a useful indicator. Equally it is not always caused or prolonged by the inability of the NHS to ‘repair’ the suffering person quickly. The NHS might not be involved at all and the health problem might be really minute (e.g., a lecturer cancelling one lecture due to a sore throat lasting one day will not visit/inform his/her GP, but will be mentioned in the statistics). Six classes are mentioned in the GHS, which we use as a source. We will concentrate on the records of four of them. We want to examine whether there is any increase or decrease in the days of restricted activity (increase potentially meaning higher absenteeism), and even in the case where there is not any increase or decrease to examine, at least whether there is stability in the days of restricted activity, because planning (of recruitment, investment, dates of production etc.) is easier when there is stability and not ups and downs in the days of availability for work.

We will begin with the case of chronic illness (about which we do not have many data) and later we will examine acute illness for which the data are considerably more.

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\[64\] See our reference to Muller and Neussus in Part I, Chapter 2.
a1) chronic illness

We will examine the records of restricted activity due to long standing illness for the ages 16-64 (ie we exclude school children and pensioners) between 1980 and 1986.

TABLE a1/1

**AVERAGE DAYS OF LIMITED ACTIVITY**
(due to long standing illness) **PER YEAR**
**INTERMEDIATE AND JUNIOR NON MANUAL 1980-86**

<table>
<thead>
<tr>
<th>YEAR</th>
<th>MALE 45-64</th>
<th>FEMALE 45-6</th>
<th>MALE 16-44</th>
<th>FEMALE 16-44</th>
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<tr>
<td>1988</td>
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</tbody>
</table>

**DAYS OF RESTRICTED ACTIVITY**
(due to long standing illness) **PER YEAR**
**SKILLED MANUAL AND OWN ACCOUNT NON PROFESSIONAL, 1980-86**

<table>
<thead>
<tr>
<th>YEAR</th>
<th>MALE 45-64</th>
<th>FEMALE 45-60</th>
<th>MALE 16-44</th>
<th>FEMALE 16-44</th>
</tr>
</thead>
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Additionally there are some data for 1988 (while there are not any for 1987) mentioning 11 days of restricted activity for men 16-44 years old, 27 days for men 45-64, 12 days for women 16-44 and 26 days for women 45-60. These data are not differentiated per social stratum thus why we have not included them in the graphics. However all four gender/age groups score better than their average for the previous years. More specifically the younger ages score marginally better (average 11.30 for men, 1988 score 11.30; and 12.56 for women 1988 score 12), and considerably better for the older ages (men average 31.14, 1988: 27; and women 28.51, to 26). While the younger ages difference can be explained even by a difference in use of decimal points: In our calculations we use two, whereas the GHS do not. The changes in the other ages can be seen only as improvements of their health conditions.
For the six ‘social stratum differentiated’ years data remain rather stable and do not prove any serious increase in the days of restricted activity. The only case in which we can observe some decrease is with the semi skilled manual male workers, while in the case of the unskilled manual female workers we have the only increase. The other cases may be just statistical variations of short term. These data can be analysed and related to our approach in two ways.

i) The days of restricted activity have not increased so, we do not have the failure of the MHM. This though implies that the days of restricted activity are so low that they do not create any problems for production or that the people who face restriction in their activities are ‘unrepairable’. Such an approach leads to our second point.

ii) That since there is not any important decrease in the days of restricted activity due to chronic illness, we can say that improvements are needed.

As a short term conclusion we can say that we do not have a serious failure as the records are not getting worse, but we still have the problem (if we relate these data to) of absence from the workplace and subsequently of high cost for production. It could be argued that more resources should be spent on this area in order to increase standards. On the other hand though, it might be that the optimum has already been achieved. If there has not been any decrease to the days of restricted activity, we cannot suggest that the MHM has been successful. The counter argument to this though, can be that a long standing illness can not be easily “repaired” in six years, and this is why we do not observe any particular changes. In this case there can be no cuts for the treatment of chronic illness, as standards will deteriorate.

**acute illness.**

In the case of acute illness we have more data than for the previous grouping. These data will be divided to two periods. A pre-Thatcherite and a Thatcherite one. The aim is to compare both the changes within each period and the two periods by each other.

1) The pre-Thatcherite period: At that time the British NHS was the model broad health system and the “envy” of a great number of other countries. What we are intending to examining here however, is not its fame, but its efficiency65. There are not any data for the period before 1973, and for the 1977-79 years, in addition the data for 1976 are not classified by the social stratum classification of the GHS.

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65 Here in our understanding of the term. Achieving few days of restricted activity and absence from the workplace for the working population.
AVERAGE DAYS DAYS OF RESTRICTED ACTIVITY DUE TO ACUTE ILLNESS PER YEAR 1973-75
INTERMEDIATE AND JUNIOR NON MANUAL.

MALE 45-64

FEMALE 45-64

FEMALE 16-44

MALE 16-44

DAYS OF RESTRICTED ACTIVITY (due to acute illness) PER YEAR 1973-75
SKILLED MANUAL AND OWN ACCOUNT NON PROFESSIONALS

MALE 45-64

FEMALE 45-64

FEMALE 16-44

MALE 16-44

DAYS OF RESTRICTED ACTIVITY (due to acute illness) PER YEAR 1973-75
DAYS OF RESTRICTED ACTIVITY DUE TO ACUTE ILLNESS PER YEAR 1973-76 SEMI SKILLED MANUAL AND PERSONAL SERVICES

DAYS OF RESTRICTED ACTIVITY DUE TO ACUTE ILLNESS PER YEAR 1973-75 UNSKILLED MANUAL

SOURCE: General Household Survey HMSO various relevant years.
Additionally there is some information for 1976 which is undifferentiated per social stratum (as the 1988 one for chronic illness). It reads 13 days for young males, 18.6 for older ones, 15.9 for young females and 18.0 for older females. In this case we have stability for the young females (with the average of the previous years, and much better records for all the rest.

i) First we are going to make an analysis of the 1973-75 data, in order to examine how health conditions developed during these years.

Male intermediate and junior non manual workers of the 16-44 age group show a slight increase in their records (ie a slight decrease in their health level, and potentially in their participation in the workplace). The other sex and age groups of the intermediate vary without giving any significant trends.

Female skilled manual workers of the 16-44 age group show an increase in the days of their restricted activity as well, while the other groups remain relatively stable.

The days of restricted activity of the semiskilled manual workers also remain relatively stable.

Last but not least there is great instability in the unskilled manual workers. In this latter case we do not find any specific trend as there were increases of up to 86.66% and decreases of 100%!

Apart of the inequalities in the health conditions of the various social class(ification)es66, there are minute trends upwards (ie to some worse health conditions), which might not mean anything in the long term; that which we consider to be the most important issue here however, is the instability in the health records of the unskilled manual workers.

As we suggest earlier in this chapter we think that stability is an important component to the reduction of cost, as it makes production and personnel planning easier.

2) In this paragraph we will examine level of the health of the people (which gives indications about the potential presence to the workplace) during the years of the Thatcher governments (1980-86). The Thatcher governments claim to be the governments that have spent more money than any other post war government on the NHS67. What were the results of the health policies though, as far as our approach is concerned? A first statistical exposition says:

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66 This corresponds with our other data about the level of health of the working class -see the tables on acute illness- and corroborates the findings of the Black Report as well. This is an interesting issue but outwith the subject of our Thesis.

67 For the issue of spending for the NHS see earlier in this chapter.

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DAYS OF RESTRICTED ACTIVITY DUE TO ACUTE ILLNESS 1980-86
INTERMEDIATE AND JUNIOR NON MANUAL


DAYS OF RESTRICTED ACTIVITY DUE TO ACUTE ILLNESS 1980-86
SKILLED MANUAL AND OWN ACCOUNT NON PROFESSIONAL

DAYS OF RESTRICTED ACTIVITY
PER YEAR DUE TO ACUTE ILLNESS
SEMI SKILLED MANUAL AND
PERSONAL SERVICES 1980-86

FEMALE 45-60

MALE 45-64

FEMALE 16-44

MALE 16-44

SOURCE: General Household Survey HMSO various relevant years.
These data are to be examined in a little more detail, due to their relevance to the period of the main interest of the Thesis.
i) For the Intermediate and Junior non-Manual workers we have instability in the length of restricted activity, (minimum range 17-21 -female 16-44 and maximum 19-32 -male 45-64). In general terms all four categories show an increase (the days of potential absence are slightly up).
ii) The Skilled Manual and Own Account non Professional indicate different trends. The young people of these groups show instability in the days of their restricted activity over the years. In these cases the days of restricted activity for males vary within a range of 5, while for females within a range of 11! The second age group shows less instability only because it shows an upward trend. The days of restricted activity become much higher for males and -despite remaining equal for 1980 and 1986- for females who also show an upward trend. In brief records of health are getting worse.
iii) For the Semiskilled Manual and Personal Services we see stability for the young (with the only exception of the 1986 male record) and instability for the elder population.
iv) In the case of the Unskilled Manual workers apart from the first comparison with other classes (the Unskilled Manual score worse) there are a number of interesting points. The young males show stability up to 1984, but have a ‘boost’ after that year which make their health condition much worse in 1985 and continues rising in 1986. The young females show instability (min. 21 days, max. 35) over this period. The elder age groups of this class (or to put it better classification) show instability and no particular trends for both genders throughout these six years.
These claims of instability will become clearer after considering the next two tables which will show not only in a mere numerical matter but in a more convincing way of percentages and rates of change. We think that this is necessary because there are cases where the range is for example 5 days and in the approach to one group we claim it is stable, while with another unstable.

The rate of change.
In these cases we have used the score of every year as the percentage difference of days lost in comparison to the previous year. So the numbers indicate the percentage change from one year to the previous and not in comparison to any absolute value, because what we want to show is the stability or instability as far as the days of restricted activity are

68 Which is relatively stable, especially if we consider that the maximum range is between two years in the next case).

69 This is obvious. An absolute range of 5 can be minimal in the case where it is created by 105-100 (5%) and huge if it is created by 10-5 (50%).
concerned.

**Rate of Change (Percentage) of Days of Restricted Activity Due to Acute Illness 1981 (-80) to 1986 (-85)**

**Intermediate and Junior Non-Manual**

- **Female 16-44**
- **Male 16-44**
- **Female 45-60**
- **Male 45-64**

**Rate of Change of Days of Restricted Activity Due to Acute Illness 1981 (-80) to 1986 (-85)**

**Skilled Manual and Own Account Non-Professional**

- **Male 16-44**
- **Female 16-44**
- **Male 45-64**
- **Female 45-60**
RATE OF CHANGE OF DAYS OF
RESTRICTED ACTIVITY DUE TO
ACUTE ILLNESS 1981 (-80) TO 1986 (-85)

Semi Skilled Manual and Personal Services

-40
-20
0
20
40

R A T E  O F  C H A N G E  (P E R C E N T A G E)
OF DAYS OF RESTRICTED ACTIVITY DUE TO
ACUTE ILLNESS 1981 (-80) TO 1986 (-85)

Unskilled Manual

-100
-50
0
50
100

R A T E  O F  C H A N G E  (%)
An analysis of the rate of change

These two tables prove our point about instability in the days of restricted activity between 1980-86. Once again the greatest differences are in the unskilled manual workers by +66.66% to -42.83% (males) or -23.68% to +62.96% (females). Other classes range significantly also. This instability gives no specific trends, while the only trends we can claim for the existing data are these of worsening health as in the last years most rates are both positive and increasing.

The main comment we have to make here is that instability is such that it will not help any long term production planning or planning for recruitment of workforce. In this sense the MHM is not functioning well as far as the needs of the capitalist mode of production are concerned. We are therefore, going to examine this in more detail in the next paragraph, in which we attempt a comparison between the records of the pre Thatcherite and the Thatcherite periods in British politics.

Comparison 1973-76 and 1980-86.

In general we can observe the overall number of days of restricted activity raising for all social classes and sex/age groups. The days of restricted activity have almost tripled for the Intermediate and Junior non manual male 16-44 years old workers since 1973 ((16 (in 1986)/6 (in 1973)). This is the most significant change, the others are just going upwards. From our point of view an “epidemic’s” explanation/answer is not adequate to explain the problem as the upwards trends remain over some 13 years and not for one or two with relative decline in the years to follow. The other interesting point is that over the same period people have become more ‘preventive health aware’. Consumption of brown and wholemeal bread has gone up, people eat more fruit and less fats etc. This could raise hopes for better health records, which we did not see in the statistical data we examined. This does not necessarily mean inefficiency of the NHS, though it makes it imperative to examine the records of the NHS itself in the previous section. How quickly and efficiently does it ‘repair’ people?

As the data of the previous section show, it seems that the hospitals work very well as long as you can get into them. The individual in hospital stay is very short, but society as a whole hasn’t achieved a very good health maintenance system as the consultation process is lengthy (waiting lists) and the days of restricted activity increased in comparison to previous years. The downward trend of the in-hospital stay may give hope for less

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70 See the whole issue of counting health and NHS in the previous chapter. For statistical proof of this point see Social Trends.

71 NB. As we do have any reference to social class or skill, we cannot comment easily on our core issue, that is the potential problems in the process of production id of extraction of surplus value and capital accumulation.
working days lost due to ill health; on the other hand though, the increasing length of the waiting lists can give rise only to gloomy thoughts for the future. However, the Thesis has already mentioned that another problem is that most of day-or short term-illness which occurs (and disrupts production) is beyond the ‘health restoring’ potential of the NHS. The most important point though, can be seen by looking at the relation between the NHS ‘performance’ and its funding and ‘legal’ functioning as analysed in the previous sections. The fact that 1982 and 1983 show the longest waiting lists and the smallest reduction of the ‘in hospital stay’ (surgical remaining unaltered since 1981 at 7.6 days) can not have only a coincidental relation to the negative increase of funding (in standard prices) in 1982. It seems that the NHS ‘performance’ is a very sensitive system and that changes in its funding result rather rapidly in changes to its capacity to deal with illness72. For this chapter the main interest is to see how much these changes have resulted in the productive capacity of the workforce. All these will become clearer in the investigation that will follow in the next subsection, dealing with the question of absence (from the workplace) due to ill health. We must however remember the issues raised in this subsection regarding the number of days of restricted activity.

Sub-Section III:
Absence from work
As we mentioned earlier this is the most important subsection of this chapter. The previous two can be examined as the reasons, or as the indicators of information about the data we are now going to approach. Here we do not have a problem whether restricted activity concerns working or leisure time, or whether the time that somebody is in the waiting list is a time of limited activity. Instead we deal with the very issue of absence from the workplace due to ill health. The main problem we face though is that we do not have any form of social classification in the given period. So despite being absent from the workplace we do not know how an important and ir - (or very difficult.) replaceable the contributor to the process of production is. Furthermore, as we do not have any clear indication about the optimal rate of attendance (we may however, assume 100%)73 we will make comparisons with the pre 1979 period. Some other issues that we have to keep in mind while approaching these data are: i) concerning the difference between the absence of male and female employees, that the number of females employed in full time jobs is about 1/3 of the number of males. This corresponds with our data (otherwise we would have had to assume that women are three times healthier than men) and b) problems of

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72 A possible correlation is one of investment for health (in terms of equipment and better salaries, less overworking etc.) and product, (in terms of better ‘performance’ or records. See Chapter 3 ‘Conclusions’.

73 See Appendix.
unemployment etc. that might spoil our sample.

We are going to use three different tables: a) 1962-63 to 1987-88, b) 1962-63 to 1978-79 and c) 1976-77 to 1987-88, needless to say that the closer we come to the years of our interest the more thorough the analysis and examination is going to be. As far as the tables themselves we have to mention that i) the numbers are referring to millions, ii) the statistical year starts ‘on first Monday in June’, iii) the age is calculated ‘at 31 May up to 1981-82; 31 March thereafter’, iv) that ‘invalidity benefit was introduced from September 1971’ and v) that 1964-65 and 1970-71 had ‘53 weeks’.

As source we have used the Social Security Statistics of various years, in order to get continuity of information. We have not reproduced the tables as they appear in the SSS, as we have decided to exclude from our Thesis the age groups of 65+ for males and 60+ for females, as most of the people in that age are pensioners. What we are quoting is the aggregate number of days of restricted activity for the two age groups which we refer to in other subsections of this chapter namely the 16-44 and the 45-64 (or 60). The most interesting cases of vertical (ie age group) or horizontal (ie year) differences will be mentioned in the analysis of the data.

![Graph of Days of Certified Incapacity for Sickness and Invalidity in Statistical Year](image)

**SOURCE:** Social Security Statistics HMSO various relevant years

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74 All these quotations from footnotes of the relative tables of several editions of Social Security Statistics.

75 Of course we are expecting elderly people to score worse (viz. more than the younger people of their sex).
DAYS OF CERTIFIED INCAPACITY FOR SICKNESS AND INVALIDITY IN STATISTICAL YEAR 1962-63 TO 1978-79

SOURCE: Social Security Statistics HMSO various relevant years

DAYS OF CERTIFIED INCAPACITY DUE TO SICKNESS AND INVALIDITY PER STATISTICAL YEAR 1976-77 TO 1987-88

SOURCE: Social Security Statistics HMSO various relevant years
A first analysis of the data for the 1962-63 to 1970-71 period.

Days of restricted activity for male workers of the age group 14-45 show a steady upward trend up to 1969-70 and a sharp decline afterwards. The worst point (the peak) were the years 1966-67 and 1967-68 with an increase of 7.4 million days more lost in the latter ones. The number of days of absence due to certified illness are so large that a conclusion that the MHM was not accomplishing its task can be drawn out of the data. Thus a better, more efficient system of health maintenance was needed. The days of absence age group of 44-65 (male) were unstable but in general they were growing up to 1970 and declined afterwards. In this case we have to mention the additional problem of instability and planning.

The female workers of the age group 16-44 show a rather stable number of days of absence going very slightly up over the years. The highest score is for women at the age of 20-24 (rather higher than the other ‘young’ women, about as high as the ‘elderly’), and we think that the best explanation for this is giving birth. For the women of the age group 44-60 the number of days of certified absence remains steady declining very slightly. What is of great interest is that there is a great difference between women and men. Anyhow the numbers in general are very low.


It seems that despite the existence of the NHS the health maintenance of British society was not functioning well. At this point we have to emphasise that the term ‘was not functioning well’ has to be read in the very narrow terms of our Thesis. It does not mean that the British people were unhealthy or even living in miserable conditions. It only means that absenteeism for health reasons was high. We think that the 88.4 million working days of young male workers, and 164.9 million for elderly males lost due to health reasons in the year 1969-70 is a very high number. Thus a better (once again more efficient for our purposes) system of health care was needed. The examination of the following years will prove whether there were any attempts to rectify the problem.

The pre-Thatcher period: An approach to the data.

The male workers of the age group 16-44 have an unsteady number of days of absence which in general is rapidly rising. From 75.3 million at the beginning of the decade we are

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76 Here we have a small difference with our previous footnote. We think though that the birth giving explanation is adequate, taking into account that this trend persists throughout the 30 years period we have examined.

77 Unfortunately we do not have percentages of the working days lost per year in order to make more accurate comparisons. We have to restrict ourselves to a comparison of the absolute numbers which might be misleading in certain cases.
facing a 92.6 at the end of it, which from our point of view is a very large number. What is even more disturbing is the growth itself. For the age group of 44-65 the days of absence remain relatively stable up to 1977 and grow rapidly thereafter. The numbers are very high and the amount of production lost seems large. What is interesting is the great difference in the days of absence among younger people. The days of absence of the female workers of the age group 16-44 remain stable up to 1976-77 and grow rapidly thereafter. The days are few in general and both the trend and the number are quite similar up to 1977 and are quite similar to those of the previous decade; but it goes much higher afterwards especially in comparison to the 1962-63 to 1970-71 period. For the age group of 44-60 we observe a stable number of days of absence (and even some decline up to 76-77) and increase afterwards. At the beginning of the period we have a smaller number of working days lost to those lost in the previous periods and then the increase in the number of days is about equal as in the previous decade. A general approach to the female records shows that the Mode of Health Maintenance (for women) worked quite well, but it could have been better, as we do not have any great decline in the days of absence.

We cannot view the period of 1970-79 in general in a good light. In general the number of days of certified inability to work is increasing. During the late seventies a large number of working days were lost. What is even more disturbing is the rate of growth of the days lost; in 1962-63 there were 68.1 million days lost (young male workers), while in 1978-79 the days lost were 92.6 million. For the older generation the days lost were 133.2 (62-63) to 175.9 (78-79). It seems that the lost production78 was quite high and that amelioration of the MHM was greatly required in the years that followed. We have already argued that the Thatcher governments tried to reduce costs and funding, and to change perceptions of the term ‘efficiency in the NHS’. The next paragraphs will examine whether the policies introduced after 1979 have achieved any better rates of presence at the workplace (viz. lower absenteeism), or whether they manifest the contradiction between extraction of surplus value and securing and perpetuating the conditions for this extraction as we claim in our theoretical hypothesis.

1979-1989

We will start again with an examination of the data concerning the male workers of the 16-44 age group. There is a steady decline up to 1981-82, while data for 82-83 are not available. After these years there is a great decline, and in absolute numbers we face the greatest change between any two consecutive years. After this decline there is instability with a slight increase in the number of days of absence due to certified illness. In this case though we should try to see some other issues -then contemporary ones- that will explain

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78 To the cost of lost production we should add: sick pay, redeployment and overtime to cover gaps etc.
this sharp decline. The 1982-84 period was the era of the highest unemployment in post-war British history. The Trades Unions were under severe attack by the government, so they had little negotiating power and space to manoeuvre79. These developments had twofold results. In the first factor (which as a result is affected by both reasons individually and by both in combination) was that people might have been feeling intimidated to ask for sick leave for the fear of facing the sack. Recruitment was quite easy, redundancy easier and the protection against arbitrary dismissal not very effective. Thus we think that we may have even seen a statistical drop in the days of absence for the aforementioned reasons. The other factor was more numerical. With unemployment scoring over ten per cent, it is obvious that less working hours were worked than in the previous years. So less (number of) working days would be lost due to illness even if the percentage remained stable. In any case the first approach to these data has to be positive though, since we try to see them even in a ceteris paribus way.

The other group of male workers (ages 44-65) show an unstable number of days of certified absence which is increasing slightly. This might mean that the older workers were more unionised or even more desirable to their employers etc., so facing the sack was not as likely as for their younger counterparts. In general, the days of absence are more than they had been the previous decade. This also might be explained by an argument that the government in these years concentrated more on the health problems of the young people than to these of the older generations.

The female workers of the 16-44 age group show the same trend as the males in that age group. The days of absence due to illness slash down in 83-84 and (at this point they differ from the males) they jump up back to pre 1978 levels. This of course cannot be cause of great optimism as the levels are not much better than they had been in the previous decade, but still they can create hope as the figures are not deteriorating. The other female age group of 44-60 shows a steady increase in days of absence. Furthermore in some cases, this increase is and not just steady but rapid. Does this mean that that the older women are neglected by the governments as the older men?

More generally all sex and age groups had slightly more days of restricted activity than earlier with the exception of 1983-84 and the years that followed for the young male workers. The historical coincidence can prove our point about the potential influence of extra-health factors (and especially unemployment) on the data about health conditions and (especially) presence in the workplace of workers80.

Overall, the Thatcher years cannot be seen as a break with the past as far as the health records are concerned. The upwards trend in morbidity and absence continues. At 1987-88

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79 See Part I, Chapter 2.
80 See Chapter I on statistical data.
there was an aggregate of 326.6 million working days lost due to certified illness. Such a record cannot be viewed positively. The rather bad attendance records led to low production and all the problems that follow. So the Mode of Health Maintenance under the Conservatives (in this case it is not solely -but certainly predominantly- the NHS which of course continues to have the lion’s share, but also the PHIC) cannot be considered to be sufficient. It could be even accused of being insufficient. If we consider that the days of absence due to certified illness had been 274 million in 1962-63 and were 326.6 in 1987-88 which means about 52.4 million or 19.12% more days, these records indicate failure than success. Especially if we consider the advanced equipment hospitals may have, the improved nutrition, habitation, smoking etc. habits, and additional recent developments such as better housing and reduced air pollution. Last but not least we have to take account of external reasons and issues like unemployment, length of the working week etc., which might decrease the number of working days per year.
Section 3

Conclusions.

As mentioned before, subsection (c) may have been most important if everything was happening under ‘ceteris paribus’ conditions. But as there are not any ‘ceteris paribus’ conditions in politics we can not comment just on the data of subsection (c), as productivity rates might have been worse and cost might go higher, thus there might have been problems in (and even jeopardy of) the process of production and extraction of surplus value, and in the process of reproduction of the productive capacity of the workforce.

The main issues for this section become: (a) Are the days of certified absence compatible with and comparable to the days of restricted activity? And (b) are the days of absence compatible with the data on waiting lists and the in hospital stay? In other words is there any relation between the state of the MHM and the level of absenteeism from the workplace for health reasons?

If it is not so, then it might be that: a) the data about absenteeism due to certified illness are inadequate to answer the question of the dangers of production and reproduction. This may be because of the problems that the reduction of working days itself and unemployment (which are not included in the very tables about ‘certified inability’) cause for our project in the suitability of these data; or b) that the fault about the potential jeopardy of the process of production does not lie with the MHM, as not all illness needs cure by it (see the ‘lecturers example’). This Section will be divided into three paragraphs respectively. In the first one we will try to compare (and examine the compatibility of) the data about absence due to certified illness and the data about restricted activity. In the second we will examine the data about absenteeism in comparison with the data about the achievements of the NHS viz. the waiting lists and the days of in hospital stay. The third one will examine the aggregate problem of these comparisons and will be devoted to our conclusions from this Chapter.

a) Absence and Restricted Activity

Though we would like to cross check all three periods this is impossible as we do not have any data about restricted activity for the 1962-33 to 1970-71 period. So, we will concentrate on the two more recent ones.

For the pre Thatcherite period (1971-72 to 1978-79) the data are -unfortunately- limited. We have data only for acute illness and only for the years 1973, 74, 75 and 76. The only

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Footnotes:

81 Could we remind the reader that such data (about percentage of working days lost due to illness) or even number of total (anticipated or planned) working days did not exist at the Department of Employment when we approached them during our research. See Appendix for details.

82 1976 data being unclassified, which is of no great importance in this paragraph.

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case of close compatibility of data for this period is the difference between the records of young and old people. Older people score very high both in restricted activity and in absence. This happens mainly for males, while females in both cases of restricted activity and absence have quite similar records per age group. Thus the main compatibility in these years is vertical/age referring.

The analysis of the horizontal/years is a little more difficult, as in both cases the changes are minute. Over the years the days of restricted activity due to illness increase slightly, while the days of absence from the workplace go slightly down. The changes are in very small numbers. On the other hand the range of years is too short to comment on trends etc. In general the only compatibility (if it can be called so!) is that in both cases we have minute changes.

The hidden foe as far as we are concerned in this approach of comparing the data about restricted activity and absence is instability. Instability in the records of the unskilled manual workers over these three years or so is quite high. From our point of view, stability of days of restricted activity and prediction of their number is a factor that can assist in achieving better productivity levels, and perhaps this is the most important issue for these three years, despite the fact that the absence records remain as relatively stable as the morbidity records for the other social classifications. Last but not least the numbers are not very high so we cannot assume any important problems in the process of production.

The 1979-80 to 87-88 period is the most interesting as it is the one having the best availability of data. We will be able to cross check up to 1986 (viz to have some indication for the 86-87 period).

For this period the most striking issue is that of the very low absence records in 1983-84. Absenteeism in these two years is slashed down to about half of what it had been. However, most trends in restricted activity between 1982 and 1984 have upward trends. There are very few that show any decline which does not indicate that the decrease in the days of absence has been the result of less days of restricted activity and thus of better functioning of the Mode of Health Maintenance. This means that the downward trend of these years could be causally related to other reasons (or that restricted activity was concerning only leisure time for a period of two years, something we think impossible). The trends afterwards seem rather similar, showing instability and in both cases slightly increasing records. The main thing that is illustrated though, is that the 1983 record decrease in absence is not an MHM or NHS achievement but was caused by other reasons.

Taking a more general approach to the question, we see that the data are not entirely

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83 See our examination of stability and planning recruitment earlier in this chapter.
84 See next paragraphs about this period as well.

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compatible, though they might be correlated. The overall trends of the days of absence are not a direct result of restricted activity but are undoubtedly influenced by the repercussions of restricted activity. This means that improving health conditions (and subsequently the health records), can help to improve the rates of presence to the workplace. To judge whether this is to be achieved by the improvement of the Mode of Health Maintenance (in Britain being the NHS) or by other factors (eg preventive medicine and/or healthier life), we will get some information in the next paragraph by the comparison of the NHS records and the absence records.

b) Absence Rates and the National Health Service Records.
Another case of great incompatibility of the data, especially as far as the 1983-84 slash down of the days of absence is under question. The days of ‘in hospital treatment’ decrease in comparison to the previous year but not as rapidly as the days of certified absence. The days of ‘in hospital treatment’ just follow their ‘normal’ decreasing trend for that period. On the other hand the 1982 and 1983 years had the longest waiting lists ever\footnote{This has to be correlated with the fact that the funding of the NHS for 1982 was ‘low’ and of negative growth in comparison to 1981, as the previous sections have indicated. The relation between funding of the NHS, morbidity and absence will be discussed in the third Chapter of this Part “Conclusions on Part II”.}, with that of 1984 being among the longest. Despite the continuation of the decreasing trend in the days of ‘in hospital treatment’ absenteeism increases slightly after 1983-84, while the waiting lists of the following years vary in length. Thus it might be that the main ‘repairing agent’ in question is the other end of the NHS ie the GP. Or it might be that absence is caused by illness that remains out of the reach of the GP (especially after the self-certification of 1982) and of course of the responsibility and ability of the NHS to contribute to the achievement of better records of presence to the workplace.

c) General Conclusions.
In an overall appraisal of the data exposed in this chapter we see that the only significantly improved figures are these concerning the ‘in hospital stay’\footnote{These data indicate another interesting issue though; the relation between spending for the NHS and the speed of health restoration. See, conclusions on the NHS.}. It seems though, that admission\footnote{As in patient. This excludes emergencies and accidents.} to hospital is an ‘extreme’ case (as far as our research is concerned). The other data show much worse records. The waiting lists are very long (and longer thanbefore), the days of restricted activity more and the days (aggregate) of absence from the workplace

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86 These data indicate another interesting issue though; the relation between spending for the NHS and the speed of health restoration. See, conclusions on the NHS.
87 As in patient. This excludes emergencies and accidents.
much higher, while the days for the ages of interest in our Thesis are higher but rather stable88. The slash down of the 1983-84 years in connection with the waiting lists shows the peak of the break with the policies of the Keynesian Welfare State more, than a success of the MHM. We claim this for two reasons. Firstly, the records of the waiting lists and of the (non) reduction of the duration of the ‘in hospital stay’, have to be be seen as being the result of the financial problems of the NHS that year, which (as claimed earlier in this chapter) indicate a shift from Keynesianism to monetarism themselves. Secondly, the improved performance of the ‘absence’ records do not contradict these conclusions. On the contrary, if we take into account the issue of high unemployment, they can even reinforce the argument. The fewer people there are in employment, the fewer working days will be lost due to ill health if morbidity rates remain stable; and, on the other hand, in periods of high unemployment people might feel intimidated to 'report in sick' for a minor problem (or might not ask permission to visit their GP etc.) for fear of increasing their chances of being fired as recruitment is easier, since there are more people looking for work.

As far as a comparison of the data with our theoretical approach is concerned, we have to mention two points.

a) The case of stability to which we refer at the beginning of this section is important. Unfortunately there are no data on the repercussions of instability to which we can refer. The only information derives from the anxiety of the BIM (1961) about the problem. There are however no original numerical data giving evidence on the subject. Of course this does not mean that because of this unavailability the problem should be considered non existent and be neglected.

b) The only thing we managed to prove in this chapter is the influence of restricted activity89 (mainly), and of the waiting lists (secondly) on the problem of absence due to certified illness. Thus, the main conclusion of this Chapter is about the non improvement of the productive capacity of the workforce in British political economy, or even its potential deterioration (if we consider the worsening absence records) during the past ten years. This conclusion has to be related to the arguments about the NHS being a ‘repairer of the productive capacity’ of the people (see our theoretical framework in Part I) and ‘the NHS not being safe in the Tories hands’ (sections 1 and 2 of this chapter). Under such a perspective, we would like to claim that Offe’s point about capitalism and the welfare state, and our point about the inherited and internal contradictions of capitalism become more apparent and valid. In total we suggest that the policies to rectify restricted activity and thus to limit absence from the workplace are sine qua non for the secure continuation of the capitalist mode of production. And since we can not see any better records after 1979 (we

88 As we have mentioned this can not a clear indicator due to the issue of unemployment.

89 According to the data available.
see even worse) using a simple functionalist approach we could claim that the government are not looking after the crucial issue of maintenance and reproduction of the productive capacity of the workforce as much as they should\textsuperscript{90}. Avoiding this ‘should’ we suggest that the contemporary governments are trapped in the contradiction between the reduction of taxation and spending for health maintenance (expressed in everyday politics terms), or between the maximisation of extraction of surplus value and the securing of the continuation of this extraction (in political economy terms). Or to answer the question as set in the introduction of the whole Thesis “do the cuts and changes in the welfare state in the United Kingdom illustrate the example of the state acting against the long term interests of capital\textsuperscript{91}?” (Introduction and Part I, Chapter 3 ‘Conclusions and Questions’). We would say yes, but the reason for this does not lie with any mistake made by the government themselves, but with the very contradictions of the capitalist mode of production.

\textsuperscript{90} See Chapter 3 “Conclusions” of this Part.

\textsuperscript{91} See next Part III, ‘Conclusions’. The next Chapter will attempt to relate the whole change in the Mode of Health Maintenance to the transition towards a ‘post fordist’ norm of capitalism in Britain.
INTRODUCTION.
The previous chapter examined the National Health Service, which is the main component of the Mode of Health Maintenance. This Chapter is going to examine the development of the Health Care Provident Associations, which in this Thesis are quoted as Private Health Insurance Companies1 (PHIC).

The main objective of the chapter is to see whether there has been any growth or any shrinkage of the PHIC in recent years especially in comparison to the shrinkage of the NHS which we discussed in the previous chapter. Thus we will be able to see if there is a ‘creeping privatisation’ of the Mode of Health Maintenance going on. Additionally, we will examine the possible reasons for the development of the PHIC by relating their (possible) growth in the market to the issue of a transition towards a ‘post-fordist’ society in which the ‘core’ workers will be insured for their health maintenance in the PHIC by their employer. Consequently the chapter is divided into two research sections (one about growth, one about transition to post fordism) and a short conclusive one.

As with the previous chapter the data come mainly from primary sources. Our sources are government publications (in a lesser extent) and the PHIC themselves, or agencies closely related to them, while we conducted an interview with the WPA Client Service Consultant for Scotland. However, we have to mention that the PHIC (especially BUPA and PPP) were not helpful as they did not give us the data needed for our research. In addition some government departments did not have any data at all and suggested we contacted the PHIC instead2.

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1 For a justification of the term, see section one below.
2 The efforts to collect data from the Provident Associations are described in the Appendix.
SECTION I:

“The Development of the Private Health Insurance Companies”.

The main private health care providers are in legal terms ‘Provident Associations’, viz organisations that are not attempting to make profits out of their operation. However, their function does not differ much from that of a commercial insurer. “At present the private health care insurance industry acts largely as a financial intermediary: it collects contributions and spends these moneys in response to billings by providers” (Alan Maynard, in Gordon McLachlan and A. Maynard 1982 p. 158). This is why we call these provident associations Private Health Insurance Companies (or PHIC, hereafter).

This section is going to examine the data on the performance of the PHICs, in terms of their finance and the number of their subscribers. In cases where subscriptions paid and subscribers are growing then we can assume that the PHIC are growing.

Sub-Section I:

Legislation about the private health option.

Contrary to what could be at first assumed, the legislation on the private provision of health services is neither vast, nor the work of the contemporary governments. The law allowing the provision of private medicine in post war Britain is the very law under which the NHS was constructed viz. the 1946 National Health Service Act (Acts of Parliament 1946, Chapter 81). Here though we should stress certain distinctions. There were (and still are) two forms of private health provision in Britain. The first is within the NHS, while the second is totally private. Within the first ‘category’ there are a further two kinds of provision of medical care. First under examination is the ‘pay beds’ system (which is the one closest to the ideal type of free system). According to this system each hospital could allocate a small number of beds in more convenient and less congested wards (provided such an allocation would not restrict access to the service by ‘non payers’) and the individual patient could request such accommodation which would be paid for. The

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3 See Footnotes 12 and (mainly) 15 as well. Ms. Stephanie Dunbar of WPA when interviewed did not disagree with the approach (see Appendix).

4 As the PHIC are in legal terms ‘provident associations’ they do not make profits, and they are obliged to reinvest their surplus. On the other hand they were unwilling to discuss their finances and classification of subscribers in great detail (see Appendix).

5 Apart from the 1899 (Ch. 19) Act.

6 Up to 1980. With the 1980 Act the ‘private “pay” beds’ were (re)introduced -after their abolition in 1976- under market terms. See our discussion of the NHS legislation in the previous chapter.

7 If the patient had to have such a service on strictly medical grounds then, s/he would have it free of charge.

8 Most of this subject is covered at the subsection about the NHS above. See Acts of 1976 (abolition) and 1980 (reestablishment).
second way health could be provided privately in the NHS hospitals was mentioned in section 5(2) of Part II of the Act allowing Doctors to cure their private patients in the aforementioned wards. While the most private way of health care provision exists at the very continuation of that sentence mentioning "or any other such hospital" (ibid.), while under these circumstances the practitioner could be paid privately by the patient, with this payment being regulated.

The functions of the private provision of health services, or to put it more accurately of the Private Hospitals\textsuperscript{10} are regulated by the "Nursing Homes" Act 1975 (Book of Statutes 1975, Chapter 37) and by "The Registered Homes" Act 1984 (1984, ch. 23). These Acts refer to the standards of services, and equipment of the hospitals and to the qualifications of people intending either to run or to work for these services (or enterprises). In general the rules are rather rigid (even those of 1984) and it is not up to the free market, but to the Secretary of State for Health and Social Security to decide whether a 'Nursing Home' should function (or continue to function) or not, while the 1980 Consultant contract allows consultants to perform private practice if they agree to a 10\% reduction of their salaries. Under such a legal system, the private health sector seems minimal and additional to the NHS. It was an optional system running parallel to the NHS. But as long as the standard of services of the NHS remained high, there was not much need of such a service. Which are the changes that made the private health option so important in recent years? We will examine this question through the parameters of resource allocation to the NHS (especially in contrast to capital investment to the Private Health sector), and the possible 'fringe' benefits for the people who opt to the PHIC choice. The last pieces of legislation on this subject are the Insurance Acts of 1981 (c.31) and 1982 (c.50); they are concerned with the health insurance options and the obligations of these companies to their subscribers in their two schedules respectively. So, as far as legislation is concerned, the Tories have achieved much less than their ideology proclaims\textsuperscript{11}. This should not be taken to mean that there have not been any changes at all. Local control over the system has declined, the NHS has been more market-like; whereas it used to be a 'non market's land', roof expenditure has been introduced\textsuperscript{12}, and conditions for private practice have become easier. Thus, the legislation of recent years has been in favour of a small shrinkage of the NHS and a small growth of the PHICs. The issue is to examine the other two remaining components ie the financial data and the statistical data viz the number of subscribers.

\textsuperscript{9} Ie not the hospital where the practitioner does his NHS job.

\textsuperscript{10} Nursing Homes in legal terminology.

\textsuperscript{11} Especially the extreme version of the New Right ideology.

\textsuperscript{12} Roof expenditure can be seen as a first and indirect way to introduce cuts.
Sub-Section 2:
The performance of the PHIC.

There are going to be two kinds of tables on this issue, one mentioning the financial achievements of the PHIC (subscriptions) and another mentioning the number of subscribers over the years\(^1\), with each table being divided into two periods (pre-Thatcherite and Thatcherite) as in the previous chapter. There is not any approach to the ‘level of services’ data (as for the NHS) as the PHIC share the same manpower pool with the NHS for doctors (there are about 12,000 consultants who are identified in the records of BUPA, private correspondence BUPA ref. PAC/CR/cm, 5 December 1990) after the consultant contract of 1980 and they mostly use the NHS ‘pay’ beds apart of their own hospitals. Additionally the private hospitals are listed together with the ‘private nursing homes, non surgical’ (viz. old people’s hostels), and this makes their statistical approach rather difficult. Thus the thesis will examine only the subscribers and the financial affairs of the PHIC, divided mainly into the ‘pre-Thatcher’ and ‘Thatcher’ periods. In particular we will examine the number of subscribers, the rate of change of the number of subcribes, the ratio between the number of subscribers to the PHIC and the aggregate population and the rate of change of it over the years. Thus, we will be able to see the expansion of the PHIC in the market. For the financial statistics we will approach the subscriptions paid to the PHIC in both current and standardised prices (neither the PHIC nor the official publications have these data, so we have created a ‘standardiser’ -see bellow for details-) and their rate of change since the mid fifties. In addition we will examine the subscriptions paid as a proportion of the GNP, to show which is the proportion of national wealth spent for private health. Last we will recapitulate on the ‘overall PHIC data’ by combining various graphs. The PHIC themselves can be divided to two large categories. The ‘not for profit’ or ‘provident’ ones and the ‘for profit’ or ‘commercial’ ones\(^2\). Recently the various commercial insurance companies have started inaugurating health care plans. The provident

\(^1\) This section will concentrate only on the number of the subscribers. Their classification according to social class is going to be done later in this chapter (section 2).

\(^2\) While the whole MHM can be divided to four large categories (according to William Laing ‘Private Health care’ OHE 1985 p.5), “Services which are both publicly supplied and publicly financed cover the bulk of the NHS. Services which are publicly supplied but privately financed include, for example, NHS pay beds. They also include, in part, services for which NHS patients pay significant charges, such as prescription medicines. Privately supplied and publicly financed services include contractual beds arrangements and, much more important now, long term care financed by supplementary benefits. Finally, privately supplied and privately financed services include the bulk of treatment in independent hospitals.” This section of the Thesis will concentrate on the fourth category, which as mentioned can be further divided to ‘for profit’ and ‘provident’.

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associations\textsuperscript{15} cover 93\% of the independent health care market, while the 'for profit' ones make up the remaining 7\%. The leading among the provident associations are the 'British United Provident Association' (BUPA), the 'Western Provident Association' (WPA) and the 'Private Patients Plan' (PPP) shared about 98\% of this market (Social Trends 1985 p. 117) some years ago, while a little before 1989 they had 92\% of the market (Soc. Trends 1989 p.131). The leading companies in the 'for profit' sector are the American Medical International (AMI) and HUMANA. We will follow the pattern of most commentators on the issue (eg William Laing, Social Trends, General Household Survey) and concentrate on the three leading provident associations and their development.

(a) number of subscribers.
These tables will show the development/expansion (in 'market terms') of the three major PHIC in the post war period, and in the Thatcherite period. This is one of the most important indicators since it will show how many people trusted the PHIC more than the NHS, during years. We will examine the number of subscribers and not people covered for two reasons. First, because it is not clear in our sources how many people are covered under a particular contract (so the number mentioned in the sources is an estimate), and second because BUPA reestimated their multiplier sometime in late 80s, so the comparison between periods would be impossible (W. Laing 1988, p. 41). The table and graph is going to be divided to two periods; first the 1945-79 and then the (detailed) 79-83.

\textsuperscript{15} In this case there is no term of 'profit' (the provident associations use this even as an advertising matter). The term mentioned in the annual balance sheets is 'surplus of income over expenditure'. We will use this as an indicator of growth though a large part of 'expenditure' is a part of 'profit' since it is given in form of higher salaries to the brokers, and top administrative and executive personnel of the associations.
The development of the number of PHIC subscribers (in thousand) 1945-89.

(a)

PHIC SUBSCRIBERS 1955-1987 (THOUSAND)

(b)

BUPA, PPP, WPA AGGREGATE NUMBER OF SUBSCRIBERS 1955-79


The PHIC had been growing rather steadily in most of the post war period. There is a cease of growth though in the mid to late seventies which is very significant, as these are the
years of the abolition of the pay beds in hospitals by the then Secretary Mrs. (now Baroness) Barbara Castle. There are two possible causes for this reaction of the people/market to this development. a) It might be the result of an well calculated reaction since a significant number of PHIC in patients were treated (through contracts) not in the PHIC hospitals but in the NHS pay beds. As the benefit went away, there was no reason for subscription to the PHIC. The next reason b) is much more political. People wanted to show their approval of the government policy and their support of the egalitarian ideas of the NHS. Overall though there has been steady growth, even in the consensus Butskellite period. Subscriptions have risen by 1,018,000 over 24 years (or 371.53%) which is an average of 42416 (or 15.48%) per year.

(c/ Thatcher period).

**BUPA, WPA, PPP AGGREGATE NUMBER OF SUBSCRIBERS 1979-88**


The increase was much steeper especially during the first years of the Thatcher governments. This indicates that the cuts in services and expenditure in the NHS, the creation of the new consultant contract, the reestablishment of the pay (NHS) beds etc were not a mere reaction to the socialist policies of the previous Labour Party governments, but a coherent policy of privatisation of the MHM which was well received by those who could pay the fees to the PHIC. The long term changes though indicate that the overall number has increased by 942000 (or 72.91%) for the whole period, an average of 117750 (or
9.11% per year which is considerably lower a percentage to the previous period. Thus, despite the numerical growth was much larger the pace of growth was not.

Rate of change of subscribers
This table and graphic will show the pace of change of the PHIC per year. It is a good indicator of the rate of growth of the PHIC. As in the previous chapters it is calculated by taking the percentage of the number of subscribers of the latter year less the number of subscribers of the previous year, divided by the subscribers of the previous year (eg 1956-1955/1955x100=growth in %). The key interest is whether the rate of growth is getting higher or lower over the years16.

(a):

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16 Of course the data have to be approached cautiously, as a lower growth rate might indicate no more than that the certain PHI market has got saturated.
The rate of growth shows a relatively steady decline up to the early seventies when the decline gets much sharper, and reaches even negative numbers. In the late seventies though the trend turns positive and upwards again achieving its second highest rate in 1979 (in comparison to 78) for the whole post war period (15.56%). The average rate of growth for the whole period is 6.75%. Earlier on we related the downward trend to the abolition of the pay beds from the NHS hospitals. However, a very possible explanation of the increase after 1978 was the condition in hospitals during the winter of discontent and the low confidence of people in the public sector at that time due to the Unions’ activity.

(c/ Thatcher period)
The Thatcherite period begins with the highest increase ever (27.47% in 1980) and illustrates a sharp downfall afterwards. There is however, a fresh upward trend in mid to late eighties. On the other hand while the whole period is much less stable than the post war one, the overall average is a little higher scoring 7.38% in comparison to 6.75% of the post war period. Considering the Tory ideology in the early eighties, and the various changes in the MHM legislation (reintroduction of the pay beds, new consultant contract, insurance legislation etc.), we suggest that at this time there was a 'New Right' attempt to privatise the MHM which proved to be rather short lived for both political and market reasons. People did not accept such a change (especially as it was a time of high unemployment and a generally unpopular government). In addition, the market got quite quickly saturated by the people who could afford paying such a cost (of course this was the reason for an additional political outcry by the people who could not afford to pay). In general though, the PHIC had a better time under Thatcherism than during the Butskellite period.

Another indicator of the growth of the PHIC is the number of their subscribers as a proportion (percentage) of the aggregate population of the U.K.\textsuperscript{17}, and the rate of growth of this proportion.

PHIC subscribers as a proportion of the population.

(a)

\begin{center}
\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure.png}
\caption{BUPA, PPP, WPA Subscribers as Percentage of Population 1955-87}
\end{figure}
\end{center}


\textsuperscript{17} W. Laing (1985,1987,1988) mentions the proportion of the people covered by health insurance contracts instead. We disagree with such an indicator since the multiplier by subscriber to obtain the population covered is both disputed and has been changed (by BUPA estimates) in early eighties.
For the first twenty years, the part of population subscribed to the PHIC grew from 0.53% in 1955 to 1.94% in 1974 an overall growth of 1.41% or an average of 0.0705% per year. Such a rate of growth indicates that the PHIC were additional to the NHS, acting as some form of convenience for the people who could afford it and not rivals to the NHS. In the mid up to late seventies (1975-77) however, we see a relative albeit short lived decline, associated with the abolition of the pay beds from the NHS hospitals on the 'legal field' and the spending on health as proportion of the GNP (which reached its highest ever - 5.49% in 1976) and the expenditure per head of the population throughout these years (see tables 5 and 6 of this chapter). Growth however, gets very sharp again in the eighties, after the reintroduction of the pay beds and the change towards more favourable conditions for the PHIC. A closer inspection of the period shows

(b/ Thatcher period)

<table>
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<tbody>
<tr>
<td>SUBSCRIBERS/POPULATION (%)</td>
<td>2.00</td>
<td>2.50</td>
<td>3.00</td>
<td>3.50</td>
<td>3.92</td>
<td>4.00</td>
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A much sharper increase during the first years and a relatively sharp increase for the rest. (including a levelling in 1986 though). In any case the increase is spectacular reaching a level of 3.92% of the population an overall of 1.63% or an average of 0.181% which is considerably higher than the previous 'growth' period (up to 1974) not to mention the

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This is also what the PHIC have been claiming to be.
negative scores of mid seventies$^{19}$.

(b) Subscriptions paid to the leading PHIC.
This table will examine the amount of money$^{20}$ spent for private health care. What is the income of the PHIC? How fast is it growing? We will examine the subscriptions paid in current and standard(ised) prices, their rate of change and the share of these subscriptions as a percentage of the GNP. Once more the graphic is in two parts (a) post war period and (b) Thatcherite period.

Subscriptions paid in current prices

\[ \begin{align*} 
\text{PHIC SUBSCRIPTIONS PAID} & \ 1955-89 \\
\text{MILLION POUNDS} & \\
0 & \ 1950 \ 1960 \ 1970 \ 1980 \ 1990 \n\end{align*} \]

\[ \begin{align*} 
\text{YEAR} & \quad \text{SUBSCRIPTIONS PAID} \\
1950 & \quad 1000 \\
1960 & \quad 800 \\
1970 & \quad 600 \\
1980 & \quad 200 \\
1990 & \quad 0 \\
\end{align*} \]

\[ \text{SUBSCRIPTIONS PAID MILLION £} \]

\[ \text{YEARS} \quad \text{SUBSCRIPTIONS PAID} \]

$^{19}$ The rate of change of the subscribers as a percentage of the population is identical to that of the population itself, therefore omitted.

$^{20}$ Obviously not the entire amount, since there are companies other than the leading PHI ones, plus the 'for profit' ones, but this is a significant part and by far the largest. On the other hand it will show the growth of the PHIC.
As with the number of subscribers, the amount of subscriptions paid gets steadily higher over the years. There is not however any change in pattern in the mid seventies during which there was a decline in the number of subscribers. The total increase in the subscriptions paid is £120.3 million (or 6683.33%) which gives an average of £5.01 million per year (or 278.47% per year). This is significantly higher than the overall rate of growth of subscribers for the same period. Given that the subscriber/insured ratio remains quite unchanged over these years (so, there was not an increase of the subscription fee due to the increase of the people insured under one contract) it becomes rather obvious that the fees had been growing rather faster than the other market prices.
The upward trend continues during the Thatcher years as well. There is an overall increase of £506.1 million (or 414.49%) which is an average of £63.26 million a year (or 51.81%). This again is quite a lot lower than the previous period, even in average per year increase. Thus the PHIC have not been growing as fast as the first approach to Thatcherism according to the Thatcherite ideology would anticipate.

The rate of change of subscriptions paid to the PHIC at current prices. These tables and graphics will consider the pace by which the subscription income of the PHIC changes. An ever increasing rate would indicate growth of the PHIC. The major problem here is that the sources mention current prices and not standard ones, thus inflation
(especially in the late seventies and beginning of eighties) influences the whole picture rather significantly, showing larger ratios than those we might have in a calculation under standard prices.

\[ \text{SOURCE: Laign's Review of Private Health Care 1987 and 1988.} \]

The rate of change of subscriptions paid is rather unstable, but within a particular band, especially between 1960 and 1970, and does not form any particular pattern probably due to the fact that the data are in current prices. There is some small correlation with the small decline in the number of subscribers in the late seventies [see I (a)], and (an even slighter one) with the downfall in the rate of subscribers in the mid to late seventies. The main pattern though, is instability with highest figures in the mid fifties and the mid to late seventies (1977), and lowest in the mid sixties and late seventies. The average of the rates of change is 19.28% which is much higher than the average post war inflation and significantly higher than the rate of changes of subscribers themselves which was 6.75%. This table examines whether there is any change in the pace of expansion of the PHIC subscriptions paid during the period we have referred to as 'more favourable for the expansion of the PHIC'. Of course we should not forget that the early eighties were years of high inflation, which dropped rather rapidly before mid 1982.
Larger bands and instability are the most noticeable characteristics of this period, whilst growth is much faster, and the peak rate is markedly different to those of the previous era, [scoring 39.80% (1982)] -whilst for the post war period is 28.59% (1976)-. The lowest one however 13.76% (1985)] is about equal to the lowest of the previous period (13.75% in 1965). While there was there was very high and accelerating growth in the first years there is a relative decline afterwards. The average of the rates of change is 22.26%, which is substantially higher (1.15 times or 15.45%) than the 19.28% of the previous period. Thus, the PHIC (under this perspective) have grown much faster in the Thatcher years than earlier.
PHIC subscriptions paid at 'standardised prices'.

The approach of using the subscriptions paid at current prices as an indicator of the growth of the PHIC is inadequate in that it does not take under account the issues of inflation (general) or of health inflation (increase in the prices of medicines etc) and market issues such as demand etc. A much clearer picture is given by examining the amount of money paid to the PHIC at standard prices. Thus we have decided to use a 'health prices standardiser' by which we hope to get the subscriptions paid to the PHIC at estimated standard or 'standardised' prices.

Health prices standardiser: this is a 'pure' number, which is the result of the of dividing the National Health Service expenditure at standard prices by the National Health Service expenditure at current prices. Obviously this indicator is different for each year, and in order to get the 'standardised subscriptions paid' for each year, we will multiply the 'standardiser' of each year by the subscriptions paid at current crisis of that particular year. A more mathematical reading of the argument (eg for year 1952) is:

\[
\frac{1952 \text{ NHS exp. stand. pr.}}{1952 \text{ NHS exp. curr. prices}} \times 1952 \text{ standardiser} = 1952 \text{ 'standardised' subscriptions paid.}
\]

This number has an advantage in comparison to the average rate of inflation as it is much more health related, while the general rate of inflation takes into account the changes at the food, household goods etc. This approach is adopted in the following tables and subsection. The one dealing with the rate of change of the subscriptions paid at 'standardised' prices, follows. This approach will show the increase/growth of the PHIC in 'deflated' terms. Are the PHIC increasing their income over the years?

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21 See the relevant section for the NHS as well, p.24 of this Chapter.

22 Unfortunately the PHIC were not willing to disclose this information, nor does it exist in the "Laing's Review of Private Health Care".

23 Since we have money both in the nominator and the denominator, they are mutually obliterated, and the outcome becomes a 'pure' number, which when multiplied by money gives a money form ('standardised prices').

24 'Health inflation' is usually higher than general inflation.
PHIC SUBSCRIPTIONS PAID
AT ESTIMATED STANDARD PRICES
1955-87


The calculations are done for 1958, 1970, 1980 and 1985 standard prices, which explains the different amounts of money estimated for some years (eg 1960). This renders an approach which uses an overall growth of the PHIC impossible since the standards have changed. In general though it can be suggested that during the three longer periods of standard prices (we consider the 1985 standard prices period too short) there was a sustained and quite standard (average) growth, with the highest being that of the 1955-60 which scores an increase of £1.88 million which is an increase of 92.61% (or average 18.52% per year) and the lowest being the next one showing an increase of 16.09 million, or 414.24% (an average of 14.28% per year). So the band of the average growth is narrow and stable. Such an approach can however be misleading, as details of particular years are
overlooked. A more detailed view of this aspect can be seen in the following Table (b)

![Subscription Payments Graph](image)


This more detailed approach shows that there have been breaks in the process of growth, and years of shrinkage, such as 1965 and 1974-1975. In general though, there is an upward trend during most of this period. The next period (which includes both the Thatcher years, and the 'Barbara Castle' years) shows that
there was very slow growth during the 1974-80 period of only 38.74 million. In other words an overall growth of 35.41%, (or an average of 5.90% per year). During this period there are two decreases one in 1975 of 1.23 million (or 1.12% less in comparison to 1974) and another one during the first year of the Thatcher administration 4.5 million (or 2.94%). During the rest of the Thatcher years though, there is a significant growth. The subscriptions paid in 1980 prices more than double between 1980 and 86, which includes the highest increase ever of 54.9 million pounds (or 31.58%) between 1981 and 82, whilst the growth is usually more than 10% (with the exemption of the last two years 1985-87).

In general there has been very rapid growth during these seven years.

A more detailed indication can be given by the examining of the rate of change of the subscriptions paid (in 'standardised' prices). In this case we look for the percentage of growth each successive year. The 'technique' adopted is the same as the previous comparisons.


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**PHIC Subscriptions Paid at Standardised Prices 1974-87**

- **1980 prices**
- **1985 prices**

The graph illustrates the growth in PHIC subscriptions paid at standardised prices from 1974 to 1987. The subscriptions paid in 1980 prices more than double between 1980 and 86, with the highest increase ever of 54.9 million pounds (or 31.58%) between 1981 and 82. The growth is usually more than 10% (with the exemption of the last two years 1985-87).
As in all cases up to now the year by year comparison indicates instability. In general though, we can observe two periods, the first up to the mid seventies and the next commencing afterwards. During the first period there is great instability, relatively slow growth and periods of negative growth. While in the post 1976 period the range of change is smaller, and there is growth in comparison to the previous years as the lowest records are as low as the mid of the 1955-75 period, while growth has been much faster in the eighties than ever before. A closer inspection of the second period shows
that the highest ever increase was in 1982 (31.58%), whilst the lowest for the period is 1987 (5.84%). The Thatcher period indicates a general growth (apart of 1980 and 87) as compared to the 1955-75 period with most years scoring more than 10%, and no negative scores are shown. Obviously there is a correlation with the number of subscribers and its growth, while other determinants are ‘health inflation’, ‘health market demand’ etc. In general though the reintroduction of the pay beds and the consultant contract of 1980 assisted in the expansion of the private health care option.

Another indication of the financial growth of the PHIC can be given by the examination of the subscriptions paid as part of the GNP.
Subscriptions paid to the PHIC as percentage of the GNP.

Earlier the thesis examined the share of the NHS in the GNP. We have already examined what the British public spend for private health care both in current and standard(ised) prices. But what is the proportion of national wealth spent on private health care? How has this share developed over the years?

![Graph showing subscriptions paid to the PHIC as percentage of GNP from 1955 to 1987.]


There has been considerable growth in the share of the subscriptions paid to the PHIC as a part of the GNP, since 1955. Overall the PHIC in 1987 claimed 0.139% (in absolute terms) of the GNP more than in 1955, which is an increase to the order of 14.9. However, the whole 1955-87 period can be divided to three smaller ones which are distinct from each other. Firstly there is a long period of slow growth up to 1974 during which the PHIC subscriptions rose from 0.010% of the GNP (in 1955) to 0.061% (1974), an overall of 0.051% in 19 years, or of 0.00268% each year. This can be seen in the following graphic which also includes the first year of 'PHIC stagnation' (1975).
Second there was a period of 'stagnation' or slow growth, which included years of shrinkage (as 1975, 1978 and 1979), ending in 1980 with an overall growth of 0.005% of the GNP since 1974. Last comes the period of rapid growth from 1980 to 1987 (the graphic includes the end of the slow growth and the preceding 'stagnation' period),
during which there was a growth of 0.083% in the share of the GNP (or of 0.0118% each year). These data are in accordance with the data on the subscriptions paid both at current and standard prices and also signify the change in the number of subscribers.

Sub-Section III: Conclusions on the Development of the Private Health Insurance Companies.
The overall development of the PHIC has been one of growth, with some periods having been more favourable (and of faster growth) than others. In general there was slow growth up to the mid seventies - when there was a period of interruption in growth - and of faster growth (to use a term from the economics of development 'a take off period') in the early to mid eighties, which was followed by a period of slow growth.

![Graph of Private Health Insurance Companies Overall Performance 1955-87](image)

**Source:** Laign's Review of Private Health Care 1987 and 1988. (and National Income and Expenditure/National Accounts CSO - 'the blue book', to create 'standard prices')

The indicators of the share of the PHIC in society (subscribers as percentage of the population) and in the total economic activity (subscriptions paid as part of the Gross

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25 The curve about the 'rate of change of subscriptions paid as a percentage of the GNP' is almost identical to the rate of change of subscriptions paid in standard prices, therefore omitted.

26 The leading article of "The Times" of 5/2/1982 reads: "Private medicine has been one of Britain's few boom sectors during the recession", while "There is a simple answer to this question. It is that demand has risen due to rising patient incomes and increased insurance coverage. This answer however masks the pathways by which NHS doctors are permitted to work in the private sector" (Alan Maynard oc. p.147)
National Product) indicate a similar trend throughout these years.

PHIC OVERALL PERFORMANCE 1955-87 PERCENTAGES

SUBSCRIBERS AS % OF POPULATION AND SUBSCRIPTIONS PAID AS % OF GNP

YEAR


clearly showing that the PHIC had very rapid growth in the first years of the Thatcher governments. The post 1970 period is of particular interest to this research, both because of its performance of decline (mid seventies) and increase (early eighties) and because of its relevance (and partly coincidence) to the period of Thatcherism, as this thesis is an attempt to examine some of the aspects of this period.

A more detailed approach to the performance of the PHIC after 1970 shows
PHIC OVERALL PERFORMANCE 1970-87

SUBSCRIBERS (THOUSANDS)

SUBSCRIPTIONS CURR. PR. (MILLION POUNDS)

1970 STAND. PR. (MILLION POUNDS)

1980 STAND. PR. (£ MIL.)

1985 STAND PR (£ MIL)

PHIC OVERALL PERFORMANCE 1970-87 (percentages)

SUBSCRIBERS AS % OF POPULATION

SUBSCRIPTIONS PAID AS % OF GNP

this performance much more clearly.
The data by themselves show the history of the PHIC quite clearly and accurately, but only indicate more general trends in British politics. The development of the PHIC is the outcome of the whole political process and activity (as is any form of policy or legislation). The aim of the Thesis is not just to examine the history of the Mode of Health Maintenance in contemporary Britain, but to search for the political reasons and repercussions of the policies adopted.

From our point of view the history of the PHIC goes hand in hand with the political history of the United Kingdom, especially in the post 1970 period which we want to analyse. The decline of the PHIC during the mid seventies is the result of the abolition of the pay beds of the NHS and its improved performance over this period27, which was such that people felt no need to 'opt private'. At a more political level the reason was the strength of the working class during that period which achieved the adoption of more egalitarian policies. Trade Unions were strong and influential during the mid seventies and it was the working class which was on the offensive by achieving alliance with the 'middle classes', so that the redistribution of wealth within society was more favourable for the worse off28. However the bourgeois counter attack in the early eighties (manifested by - among other things- the election of Mrs. M. Thatcher, the (anti) Trade Unions policy and legislation, monetarism, privatisation, and the first Howe budget), which on an ideological level was signified by the attack on the welfare state and the National Health Service29, and on the level of policy by the change in health policy (reintroduction of pay beds under 'market' requirements, and new -1980- consultant contract) gave the opportunity and incentive to people who could afford to pay for private health care to do so, and to the PHIC to expand their services. Thus there was an increase in the performance of the PHIC in early eighties30. In addition we should remember the tax incentives given to the elderly later in the decade in order to encourage them to opt private since they both helped the PHIC expand their market and manifested the political-ideological stances of the government. This upward trend ended (or was reduced) in the mid eighties for a variety of reasons.

Firstly there was an stoppage in the process of the privatisation of the Mode of Health

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27 More at the next Chapter 3 'Conclusions' in the section about the comparison between the NHS and the PHIC.
28 However the rates of taxation for that period do not indicate this as they are divided to the 1972-75 (high taxation rates) period, and the post 1976 which gets as low as during the early seventies (Heath governments) period. See Inland Revenue Statistics for thee years.
29 See Part I Chapter 1 about the change of policies signifying the bourgeois 'counter attack' and the section 'Ideology' of that chapter discussing the ideas of Hayek Friedman and Buchanan in particular.
30 Plus the condition of the NHS hospital during the winter of discontent and the long waiting lists (see previous chapter) etc..
Maintenance itself by the government", which had problems in implementing their ideology. As we argued in Chapter 2 of Part I, the working class was on the defensive during this period, and had been defeated on many fronts, such as industrial relations, general welfare expenditure (housing in particular), but had not been defeated to such an extent as to be easy for the government to abolish the pro-working class Mode of Health Maintenance (being the NHS) and replace with another such as the 'health vouchers'. The Labour Party was up in the polls (due also to the problems of unemployment etc.) and when (a little later) in the 1987 General Election Labour mentioned the NHS issue there was panic among both the Conservatives and in the 'City' about the possible outcome of the election (this is the 'wobbly Thursday' 4th June 1987 as referred to by Ray Whitney 1988, p. 5). Additionally, these policies were rejected by the middle classes and the petit bourgeoisie which are both users of the welfare state and a significant number of whom work for the welfare state. Last but not least the welfare state ideology was (and still is) strong in these classes. So there was a danger of a change of class alliances as the middle classes, petit bourgeoisie skilled manual workers and the white collars could return to their old alliance with the (rest of the) working class, at least in their voting attitudes. These events indicate that class struggles and alliances were at such a level that did not allow the bourgeois offensive some certain policies. These were the main political reasons which did not allow the government to continue on the cuts/privatisation of the welfare state path much more, at least as far as the NHS is under consideration. But there were some reasons related to the market and to the PHIC themselves. Firstly, we would like to argue that the market itself got saturated. People who could and were willing to buy Private Health Care, did so in the first years of expansion of the PHIC (up to 1982-3) and the PHIC could not find any other clients (in an expanding scale) in the U.K., especially as long as new incentives such as tax cuts were not given to a large number of people to opt private. Secondly, fees were so expensive that people on an average salary could not afford to pay especially since they had other financial commitments, such as mortgages which had high interest rates for parts of that period.

31 Highlighted by the withdrawal of the 'voucher system' when the discussions about it were still in an embryonic stage.

32 Goodin and LeGrant are close to identifying the people who work for the welfare state as being the middle classes (see 'Not Only the Poor' pages 148 and 151 and LeGrant 'The strategy of Equality' p.126). Additionally they claim that the middle classes make better use of the welfare state than the less well off, through either infiltrating the programmes, or using them for their own benefits. (see 'Not Only the Poor' pp 203 and 224, and "The Strategy of Equality" pp.27, 30, 31, 33).

33 This actually happened in the late eighties, early nineties again. The policies of water privatisation, Poll Tax, and the NHS reforms made people reconsider their political stances.

34 "Now (9/Feb/1982) we can see that the (expansive) curve, as we expected is flattening out" Derek Damerell (Chief Executive of BUPA) letter to 'The Times' 9/2/82. Later in his letter he asks for more collaboration with the NHS. See next footnote as well.
In short, though the period was still favourable in the mid and late eighties, it was not more favourable for the PHIC than the early eighties one\(^35\), so to assist a further expansion of the market, while the market itself at these prices was saturated. However (as we mentioned earlier) class struggles and alliances were such that did not allow a whole hearted adoption of more favourable policies. The PHIC (as long as these more favourable policies are not adopted) remain in close relation to the NHS policies. They are an ‘addition’ and not a ‘rival’ as most people can not afford to pay, so they aim at a specific market. The only way out of the slower growth of the mid to late eighties back to high growth of the early eighties would be (for the government) either to starve the NHS, something that the government could (and can) not afford politically, or to create much more favourable conditions (as mentioned in footnote 34 and earlier in this argument) which again would cause great political problems, in the form of changing class alliances, or a combination of the two solutions.

\(^{35}\) Eg. there were not tax reliefs for subscribers under sixty five introduced, more pay beds installed at hospitals, a consultant contract allowing more than 10% of practice to be in the private sector, similar arrangements for the GPs etc. See ‘Private/Public mix for Health’ pages 63,118 and 142, plus Derek Damerell (Chief Executive of BUPA) letter to the Times 9/2/1982 calling for more collaboration with the NHS. However, the then Tory government did not have either a coherent or a favourable policy in the early eighties, despite the ideological stances; see Private/Public Mix for Health (MacLachlan and Maynard 1982) Introduction pp.9,10.
SECTION 2:  
"Who Goes Private and Why?"

This section will examine the question of the relation of the health policies and the developments in the PHIC to the 'Post Fordist' state of capitalist production*. As Robin Murray (1989, p. 46) observes "[t]he EETPU's lead in embracing private pensions schemes, BUPA, internal flexibility, union organised training and single company unions are all consistent with this path of Post-Fordist industrial relations" (underlining by the author). However from our point of view, it is rather premature to claim that capitalism has reached a 'Post Fordist' norm of production, and it is even more premature to describe the current state as 'Post Fordist'. Our opinion is that the whole automation process in one part of the industry (and the subsequent division of the workforce to 'core' and 'peripheral'), has on the one hand to be both better established and become more explicit in industry, and on the other to be followed by certain state policies (in eg education, pensions systems, industrial relations legislation, housing policies etc.). Thus, though we would be inclined to agree with Murray over the methodological observation we think that it is very premature to claim transition to 'Post-Fordism' due to the inadequacy of data, and to the fact that (according to Murray's evidence) the transition is achieved through a union and not the employer.

Changes in health policies are a small but very significant and important part of this process. Their significance and importance lies on their function as the maintenance providers of the productive capacity of the workforce as claimed in the previous chapters. Moreover, the way these policies are carried out is indicative of the form of capitalism and capitalist state. Yet again, the analysis of the health policies alone, would not prove the existence of a 'Post Fordist' state, but rather a trend and tendency towards the transition to a 'Post Fordist' state. In order to approach the question, this section will examine the social

* Our original intention and hope was that this short section should form a whole Part of the Thesis and research project, but in the process of research we discovered that it was not possible to collect the data needed as they are classified as 'commercially sensitive' by most of the PHIC which declined to answer our questions. With the notable exception the Western Provident Association which was more helpful, but the information available was neither adequate nor convincing or conclusive. The information collected from the two leading insurers is less than limited. BUPA's letters mentioned that "I am sure you are aware of the commercial sensitivity of information, and although we would not be prepared to discuss or supply confidential information and plans, it may be possible to discuss the general issues" (Private Correspondence 5/12/90, BUPA ref. PAC/KR/cm, signed by Mrs. Kate Roxburgh, Policy Research Manager.) and later on (27/3/91) "I regret that I do not think it would be advantageous to you to arrange for you to come to BUPA because the subjects you wish to discuss are commercially sensitive and we would not like to discuss these issues outside the organisation". The Private Patients Plan declined to answer these questions giving information only on their 1989 Report and Accounts. (Private Correspondence, PPP ref. A/wp/dc2, 26 November 1990, signed by Ms. Debby Cahalane, Administrator, Strategic Communications). See Appendix for more details.
classification of the PHIC subscribers, and the way of payment of their subscription. Are the working class people covered by the PHIC the category of workers we call in Chapter 1 of Part I ‘flexible/core’ workers? If yes, is their subscription a part of the wage package? And how was this package negotiated? The hypothesis was based on the theories of the ‘Post Fordist’ mode of capitalist production and regulation. In such a structure the working class is divided into two ‘tiers’ the ‘core’ workers who get better conditions of work, and the ‘peripheral’ workers who live in the margins of society. This is due not only to the need for specialised labour in modern industrial societies but to regulation and control of the process of production. ‘Core’ workers are supposed to make no strike agreements with management and to identify themselves with the company and the finished product. On the other hand they enjoy better conditions of work, and no visible distinctions from their managers. This whole process is seen as a part of a general strategy by capital and the state to control the working class through incorporation, and to achieve better condition for production and legitimacy.

Unfortunately (as mentioned earlier) there were not any data available to help us reach any clear and decisive conclusion. In the rest of this appendix we will present all the data we managed to collect.

M. J. Smith (BUPA member) in a speech to the IHA Annual Conference (18/10/1990) entitled ‘Expanding the Market. Are Insurers in the Driving Seat?’ mentioned

“The market has traditionally been split into those people buying it for themselves, the individual market, those people who are covered by their companies and those people who buy it for themselves, but pay through the company payroll, or gain a discount through been a member of an association or a trade union or any other group”.

Such a categorisation of subscriptions is mentioned in the General Household Survey of 1982 as well, but the GHS claims that with the increase of subscription the distinctions are (were in 1982) more blurred than in the past (GHS 1982, p. 157). We are interested in the second form of subscription for Social Class(ification) C2. M. J. Smith continues stating that

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37 According to CSO standards, ‘Classification of Occupation’. See also previous chapters.

38 See our references to the agreements between EETPU and various hi-tech companies and the non unionisation in the electronic industries in Scotland in the eighties in Chapter 2 of Part I, (in section ‘definitions’).

39 In addition to the Provident Association we approached the Department of Trade and Industry, the Department of Employment, the Department of Health, the Trade Unions Congress and the Confederation of the British Industries. None of these organisations had any data relevant to the research while some suggested we should approach directly the Provident Associations themselves.
“company purchase market has shown the most dramatic growth, and its proportion of the total market is now much higher than in 1978, whilst the individual market’s proportion has fallen......nearly three quarters of health insurance is controlled by companies either directly, or deducted from the wage packet of their employees ...” (pp 2-3).

While BUPA’s document “Overview of the Private Sector of Health Care in the United Kingdom” (unsigned and undated, obtained from BUPA through private correspondence) mentions that “BUPA estimates that it insures some 44,000 company groups; PPP suggests that around 50% of its business is in the corporate sector” (p. 1). Additionally Ms Jackie Wiggins in a speech for Providers Roadshow entitled “The Pursuit of Value for money” (BUPA ref. GSC/15/8/89/Wiggins.pro) said ‘At least half of BUPA subscriptions are bought by corporate clients on behalf of their employees’ (p. 3). This information is similar to the answers given by Ms. Stephanie Dunbar (WPA Client Service Consultant for Scotland) when interviewed by the author.

With regard the particular focus area of this Thesis M.J. Smith mentions that companies offer health insurance to their managerial and professional staff but not to their blue collar staff, and that it is mainly the upper strata that ‘opt private’ (pp. 3-4). This approach is corroborated by the data of the General Household Survey of 1982 ‘very striking differences emerged in the proportion of informants with private medical insurance in different socioeconomic groups. Overall, 23% of those in the professional group were covered by health insurance compared with only 2% of those in semi-skilled and unskilled manual groups (p.155)

While this profile did not change in 1983, the change in the next data available from the GHS is minimal:

24% of Professional insured
22% of Employers and Managers
9% of Intermediate and Junior non manual
3% of Skilled Manual and Own Account Non Professional
2% of Semiskilled Manual and
1% of Unskilled Manual.

(GHS 1986 p. 140, Figure 10K)
Furthermore the GHS data for 1987 (p.35) show:

27% Professional
23% Employers
9% Intermediate
3% Skilled
2% Semi Skilled
1% Unskilled.
While there is a slight increase of the C2 subscribed over these 5 years, but there is limited information\(^{40}\) whether their subscriptions are individually or company paid, the change however is so small that it cannot suggest any significant change.

Ms. Dunbar mentioned that (for the question of C2s been insured by their employer) there is some increase but there is not any specific evidence for change. However, some time ago companies used to insure their directors whereas now they insure other employees too. This mainly consists of junior managers etc. and some Skilled Manual workers are included, but the extent of this was not known to Ms. Dunbar.

On the more specific issues of preventive medicine and occupational health BUPA’s ‘Overview...’ mentions (paragraph 17) that BUPA has built the largest network of medical centres in Western Europe for health screening and (para. 24) ‘BUPA occupational health provides a complete advisory and assessment service to help companies mange the health of their workers. It is aimed at providing a service for companies with between 300 and 500 employees which do not have their own occupational health departments, but also as a back-up service to those larger companies which do have their own departments’. This is an important issue with regards the research, as it is directly related to health maintenance and the prevention of absence. However there is no mention of which category of workers these centres work for and monitor.

**Conclusion on section 2**

From these limited data it seems that the transition towards Post Fordism did not happen in the area of health care during the last decade. The information given by Ms. Dunbar indicates that there are some signs of it now. However data for both cases are so limited that any conclusion about trends and tendencies is unsafe and premature. Moreover, a conclusion claiming that we are in a post fordist society seems wrong as only 2% of C2s are insured in private health, though the method of payment of their subscription fees is unclear.

It is possible that the issue of the growth of the PHIC in relation to the changes in industry and society is a question for the historian of the future.

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\(^{40}\) In 1982 42% of the subscriptions of ‘manual’ workers was paid partly or fully by their employers. In 1983 it was reduced to 37% and 1986 increased to 44% (GHS 1982 p. 172, 1983 p. 177, 1986 p.143 respectively). There is no information on the skills of the manual workers though. On the other hand such trends can be seen in all socio-economic groups, and employer’s payment of subscription in broad terms is even for all socio-economic groups. The main differences are not between the groups but between full time employees, part time employees and the unemployed (see GHS 1986 p. 143 and 1987 p.37).
SECTION III:
"Conclusions on Private Health Insurance Companies."
The PHIC performed quite well during the years of the Thatcher governments especially during the first period (1980-83). Despite these records (which showed some decline in subsequent years) it is the NHS which remains the predominant factor of the MHM, regardless of the cuts and changes that have resulted from its shrinkage\(^{41}\). The very rapid growth of the PHIC seemed short lived probably because of an easy saturation of the market due to high subscription prices and the potential political cost of alleged health privatisation via starvation of the NHS and expansion of the PHIC. Private health subscription remains a habit of the upper classes and strata, and seems to be more of a 'convenience' than a 'necessity'. This is of great importance for the thesis as neither the public in general, nor employers in particular have lost their confidence in the NHS and do not seek help in restoration of their health (maintenance of their -or their employees’- productive capacity) from the PHIC. There has been no indication of a conscious shift from the NHS to the PHIC as far as this maintenance is concerned and employer paid subscription is still more of a fringe benefit than a productivity securing policy, either for the 'core' ‘post-fordist’ personnel or for the entire one.

Nether do the changes indicate any transition to a two tier ‘post-fordist’ system, although this might have been caused by the secrecy of the PHIC as far as the data were concerned\(^{42}\). The next Chapter 3 “Conclusions on Part II”, will recapitulate the arguments raised in both research Chapters and discuss some of these issues again in more detail.

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\(^{41}\) For a detailed analysis of the relation between the NHS and the PHIC see the next Chapter.

\(^{42}\) However, it could had been shown in the General Household Survey data. The GHS data do not indicate such a change.
CHAPTER 3

“CONCLUSIONS ON PART II”

INTRODUCTION:
This Part has up to now examined the development of the NHS, the development of morbidity and absence in the first chapter, and the growth of the PHIC in the second. This Chapter will compare the development of the two elements of the MHM and will examine the relation between them in order to see whether there is any conscious privatisation policy going on, and what the limits of such a possible privatisation are. Examining the limits of privatisation and (in relation to that) the limits in the cuts provide an answer to the theoretical hypothesis about the importance of the class struggles for the formation of policy1.

Additionally, the chapter will approach a question that has remained unanswered since the end of Chapter 1. This is the issue of the relation between the NHS functions and funding as a cause, and morbidity and absence from the workplace due to health reasons as an effect. Thus, we will answer the postulations of the ‘functionalist’ argument of our theoretical hypothesis, about the NHS being the ‘necessary repairer’ of the productive capacity of the workforce. Most importantly such an approach confirms the validity of our claim about the empirical testing of the theoretical presuppositions.

The Chapter consists of three sections, one answering each question raised and a third one recapitulating the main arguments. As a concluding Chapter has most of its sources in the previous Chapters and Part I, plus some secondary comments wherever applicable.

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1 This issue is approached in more detail in the following Part III of the thesis.
SECTION 1:
‘National Health Service and the Private Health Insurance Companies: a direct comparison.’

The aim of this chapter is to compare the NHS with the PHIC and vice versa, in order to examine the issue of relative growth and shrinkage, so as to give a clearer idea of the whole issue of privatisation of the MHM in contemporary Britain.

Obviously there cannot be any direct ‘size’ comparison between the two components. The NHS is the largest employer in the U.K., and one of the largest in the world, and has to look after the entire British population and not a specific number of people in other words “the private sector responds to demands, while the public sector meets needs” (R. Klein in MacLachlan and Maynard 1982, p. 120). Additionally, the PHIC have not got large and important accident and emergency services and departments; additionally, they are selective as far as some categories of clients are concerned. There will be a comparison of growth of the two components. Which part of the MHM is showing a faster growth than the other?

The clearest financial indicator of growth (or shrinkage) of any of the two components is the rate of change of its ‘income’ at standard prices. For the NHS we have used the ‘Rate of Change of NHS expenditure at standard prices’ and for the PHIC the ‘Rate of Change of Subscriptions Paid to the PHIC at Standardised Prices’, making a combination of the two graphics. The picture for the whole post war period

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2 See our reference to O’Connor 1973, p. 64 about the differences in the rationale of the state and of the commercial companies in Part I, Chapter 2.

3 Eg. the elderly who are excluded either through high cost of subscription or (more directly) through non acceptance, unless for renewal. Or for people of the same age through classification of areas as more or less expensive. See brochures of BUPA, PPP and WPA.

4 Our estimate; see Chapter 2.
shows that in general the PHIC had been growing faster than the NHS but not at a significantly better pace, while there had been short spells of NHS achieving better records of growth than the PHIC (e.g., mid-sixties and mid-seventies). From the early to mid-eighties the PHIC perform much better than the NHS while in the late eighties the difference gets smaller again. In general it is the PHIC which have a broader range of growth indicators than the NHS, but again we can see the three periods in the development of the PHIC, especially in comparison to the NHS. This strengthens the point that the development of the PHIC is in close relation to the overall performance of the NHS. In a more direct comparison of the two components, though, we have deducted the rate of growth of the PHIC from the rate of growth of the NHS. This comparison gives

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5 Not only expenditure development; but abolition of pay beds, strikes etc. as well, see previous Chapters. 

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showing the three periods much more clearly, and the better PHIC performance in the post 1979 period. Examining the last twenty years period in more detail, we see

the differences between the 'Castle' and 'Thatcher' periods rather more sharply, while the more direct comparison shows
the great difference between the PHIC growth and NHS shrinkage in the early eighties. This closing of the gap is not because of better funding of the NHS, which has some of its (s)lowest rates of growth over that period, but due to the worsening performance of the PHIC because of the reasons we mentioned earlier in the Thesis.

An additional picture of the relation between the NHS and the PHIC can be given by another comparison. In this case we will examine the subscriptions paid to the PHIC as a percentage of the expenditure allocated for the NHS.

this approach shows the continuous growth as well and the three main periods of the development of the PHIC. Focusing on the post 1970 era, indicates

<table>
<thead>
<tr>
<th>Year</th>
<th>1970 Stand. Prices</th>
<th>1980 Stand. Prices</th>
<th>1985 Stand. Prices</th>
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<td>0.0</td>
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<td>1985</td>
<td>3.0</td>
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the differences between the pre Thatcher period and the Thatcher one, as well as the two phases of the Thatcher period.

**An overall comparison**

Above, when commenting on the NHS the Thesis concluded that it has shrunk in the eighties while it was expanding in the seventies. In the Chapter relevant to the PHIC we suggested that the PHIC have been growing for most of the post war period with the Thatcher era being the one of the highest growth. The direct comparison of the two components of the Mode of Health Maintenance in contemporary Britain confirms and reinforces this view. The PHIC both perform better than the NHS and increase their finances in comparison to the state expenditure for health. The share of the private sector of the MHM has expanded considerably in the past years, and the rate of growth of this sector is better than the one of the state sector. In other words the PHIC have grown in comparison to the NHS and subsequently the NHS has shrunk in comparison with the PHIC.
Now we turn to examine the question of the relation of growth of the NHS and the PHIC. There have been two factors determining the rate of growth of the NHS and the PHIC. The determinant for the NHS was mainly (if not only) its funding, while for the PHIC it was both the funding of the NHS and the legislation about, it especially for matters as ‘pay beds’ and ‘consultant contracts’. The private sector needs the NHS ‘to provide the most expensive and most long term care for those with the least financial resources. On the other hand the NHS needs the private sector as a political safety valve’ as people, who wish so and can afford it, opt private (R. Klein o.c. p.102). At this point Klein neglects the issue of pay beds and consultant contract as factors that increase the dependence of the private sector on the NHS (or the state policies in general). While the ‘efficiency performance’ of the NHS was more related to legislation, and its growth to funding, the ‘market performance’ of the PHIC was more related to the NHS and the legislation concerning the ‘fringes’ of it.

From the early fifties to mid seventies both components show a slow growth. During this period the rate of personal taxation was following a general upward trend, while corporate and company taxation was getting lower (except of the period of late sixties Labour administration, for company taxation).

In the mid seventies there was rapid growth of the NHS and a hiccup in the rate of growth of the PHIC. It is during this period that the dependence of the PHIC on the NHS legislation and expenditure becomes more apparent. Earlier on in this Thesis, this period was called a period of egalitarianism; however, the changes in the rates of taxation on all three forms of income after 1975-76 indicate a more ‘pro property’ policy than in the years 1973-75. Additionally in the 1973-75 period the NHS was having higher rates of growth than the PHIC, and this is the period of the highest taxation as well. Since the expansion of the welfare state and of the egalitarian ideas and ideals associated with it are usually taken as indications of strength of the working class, it can be claimed as a period in which the working class was strong.

Early eighties show a complete reversal in the rates of growth of the previous period. The NHS gets shrunk, while the PHIC grow rapidly. Once more the relation between NHS

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4 Of course on the one hand legislation influenced the ‘efficiency’ of the NHS -but not its growth- and the efficiency of the NHS influenced the growth of the PHIC, and on the other industrial disputes within the NHS, influenced the development of the PHIC as people opted private. In both cases though it was the NHS (and the NHS efficiency and ability to cope with health problems in particular) which was the key reason for going private.

7 See the discussion about taxation in post war Britain in Chapter 4 of Part I.

9 Rate of change of NHS expenditure both at current and standard prices was going higher, rate of change of nurses employed by NHS was growing as well, while this did not happen for doctors. See Chapter 1 of this Part.

9 The PHIC had negative rates of change in 1976.

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expenditure and legislation and the growth of the PHIC is very clear, as this is the period of
the slowest growth of the NHS in real terms (1982 been negative, and the rest been hardly
over 1%), and on the legal level, of the reintroduction of pay beds at the NHS hospitals and
of the pro-private practice consultant contract. But this period did not last for long.
The PHIC continued growing in relation to the NHS up to the moment the market got
saturated in the mid eighties, mainly through NHS (at least coded as ‘NHS’) legislation.
The NHS continued shrinking in financial and service infrastructure and personnel terms
but there were not any new ‘pro private’ initiatives. The ‘pro people’ Mode of Health
Maintenance was under attack while taxation10 was (surprisingly) a little higher than during
the period of expansion of the NHS11.

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10 Taxation is the main way of funding state expenditure. Expenditure ‘needs’ and ‘priorities’ though change as well during the years. The distinction between ‘need’ and ‘priority’ is a political issue. We will give ‘need’ a more technical meaning as the absolute minimum in order to sustain existing services, or as a requirement by legislation. This meaning covers the 1% increase per year in the expenses of the NHS for the treatment of the aging population as C. Ham argues, or the payment of a higher amount of money as dole for the unemployed in periods of high unemployment as the early eighties. By ‘priorities’ we mean expenditure related to government’s choice, especially when shows some form change of attitude from previous periods, as defence spending during the Thatcher years. Of course the whole area of distinction between ‘need’ and ‘priority’ is rather grey, and depends both on personal political standing and on the current dominant ideology. In general though it can be claimed that Public Spending Requirement grows over the years, while this does not necessarily mean that Public Spending itself rises as well.

11 But it was slashed for the higher incomes.
SECTION 2:
"The Potential Results and Repercussions of the Changes in the Mode of Health Maintenance".

Introductory remarks.
This Thesis has up to now analysed the growth of the NHS and of the PHIC, their relation and the results of the whole health maintenance policy as far as the productive capacity of the workforce (in terms of attendance to the workplace) is concerned. The aim of this section is to examine the relation between the funding of the NHS and morbidity and absence from the workplace due to health reasons.

This section will thus examine the relation or the correlation between facts and figures discussed throughout Part I and Chapter 1 of Part II. The objective is to form a causal relation between morbidity and absence from the workplace (as discussed in the previous chapter), funding of the NHS and morbidity (viz. linking the two main sections of Chapter 1 of this Part) and subsequently an (empirical) relation between funding of the NHS and absence from the workplace. Additionally this section will (first) approach the question of legislation and ideology and their results as far as absence is concerned, and the potential feedback towards the policy makers. Last, we will spell out our first conclusions from this approach, and raise the issues for the next Part III.

Legislation and Ideology and their Relation to Morbidity and Absence.

a) Legislation/organisation.
It seems that the most important problem of the NHS is efficiency. The term is central for a great number of the NHS documents and each of the NHS reorganisations, but remains undefined, or at least without a very clear definition. The definitions given can be divided to two groups these of 'efficiency as shorter stay in hospital and welfare in general' and provision of welfare, and those of 'efficiency as value for money'. After 1980 there has been increasing centralisation from the to the Secretary of State and quasi privatisation (especially after 1991). Indications about privatisation existed before 1991 also, with prime examples the reintroduction of the pay beds according to demand (and not according to not disruption of the access to the hospital - as in 1968- in 1982, the opting out for cleaning and catering and the self fund raising for hospitals and health authorities). Later, the NHS was required to become more 'business' like, and after 1991 managers will be appointed to run the hospitals in the competitive market. This section will relate changes in specific years (1968, 1973, 1975, 1980, 1982 etc.\textsuperscript{12}) to absence and (after 1980)

\textsuperscript{12} Of course the 1991 changes remain beyond the research project for the Thesis since they are very recent and they have not shown their results as yet.
morbidity. For the period of the Thatcher administration which is of particular interest to our research, we have to reiterate that in Chapter two when dealing with the issue of legislation under the Thatcher governments we mentioned two main elements. A quasi privatisation of the (functioning of the) NHS and a greater centralisation of control to the Secretary of State. We should however mention that despite the legal changes and the attempts to achieve better running of the service, the performance of the NHS in terms of waiting lists and duration of in hospital stay did not show any improvement, as we have already seen in Chapter 1. Additionally the data on absence show that there was no particular success in this area either. Thus, in the issue of efficiency¹³ legislation seems to have failed, and furthermore it seems that the argument that as well as money the NHS needs 'more efficient running', is hollow as far as efficiency is not defined.

b) Ideology and class alliances.

The choices and policies highlighted in the previous section (and throughout this Part) have been inspired by the New Right ideology of Hayek, Friedman, Buchanan and others. As we have referred to the most crucial elements of this ideology earlier, we would not like to go back to them in detail. The key claims of the New Right ideology are reduction in taxation/expenditure (since taxation limits the freedom of the individual to dispose of his/her money); anti bureaucracy ideology (as the bureaucrats become more powerful and restrict freedom of the people); ‘choice’ and ‘freedom’ (freedom defined as absence of constraints and being ‘Free to Chose’). Last but not least there was a distaste for the welfare state and the National Health Service in particular. These institutions were (are) under ideological fire both due to their own capacity and due to the fact that they are the outcome and realisation of each of the ‘hindrances to freedom’ mentioned earlier. Such a critique of the NHS which went through all the post 1980 period (from the government, as Mrs. Thatcher was critical to them as leader of the opposition) did not seem to help the solution of the problems of the NHS as a contributor to the health maintenance of the workforce, as was the case with legislation. Some of the ‘core’ ideological arguments (choice, vouchers¹⁴, privatisation etc.) collapsed as early as 1982. Other elements of this ideology have started to be altered in recent time especially after the replacement of Mrs. Thatcher by Mr. Major at Number 10. From our point of view the reasons for abandoning the extreme pro market ideology are related to the limits of ‘world’ and ‘health conditions’

¹³ Efficiency remains an undefined term in the literature about the NHS. If it is just related to lower expenditure and 'value for money', then any cuts in expenditure that do not destroy the whole NHS are 'efficient'. We would like to use the term in another sense though, meaning the minimising of illness, waiting lists, in hospital stay and subsequently absence from the workplace.

¹⁴ Replacing the NHS with the provision of vouchers and leaving people to 'buy' health with these vouchers in a free market. This project was short lived and the government abandoned it in 1982.
over ideology and incompatibility of ideology with society, and not to limits of ideology itself. Full implementation of such an ideology could not go ahead as it was becoming apparent that the NHS would collapse and such a collapse could cause problems to the health levels of people. This is what we referred to as problems in implementing the ideology as set by the ‘world’, viz. by the very contradictions of capitalist economy. Additionally, there were some other problems in this implementation. These are related to reaction and resistance this ideology and its implementation faced. The reaction came mainly from three sides, the NHS personnel, the ‘wet’ Tories and the electorate, manifested by the support given to the other parties, and the initiatives these parties have to offer. This reaction has its reasons in class issues as mentioned in Chapter 2. The limitation was with the certain hegemony of the bourgeois class which both was not consolidated and which the Tories tried to abandon to the (assumed) financial -and other- benefit of the better off, prior to securing the alliance of the ‘middle classes’. This resulted in both a change of alliances and a stronger resistance by the working class which showed the limitations mainly of the implementation of the ideology and not so much the limits of the ideology itself.

Funding the NHS, morbidity and absence.
Firstly we will consider the Relation Between Morbidity and Absence which is the easiest to prove. Sickness as used in the first chapter of this Part is limiting by definition. So people who are sick or ill are unable (or at least find it difficult) to turn up for work. The main problem concerning this question is not the relation itself, but the possible divergence from it due to other ‘external’ reasons. These could be cases of being ‘slightly’ ill but mainly bored or ‘not satisfied with work’ but declaring ill, especially after the change to ‘self certification’ of illness for less than a week, or contrary in periods of high unemployment and danger of been fired if showing high absenteeism, people could report to work but be of ‘lower productive capacity’ in the workplace.

So, of greater importance for the Thesis is the Relation Between NHS Funding and Morbidity. In the argument that follows we will attempt to see the restoration of health as a product of human labour. The health personnel (doctors, nurses etc.) have already been referred to as ‘repairers of ill people’. Now we will see them as ‘producers’ of healthy people, who use some certain ‘tools, and equipment’ in the process of their work. Thus, health care provision follows the rules of production. In other words the higher the

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15 The argument should not be read in the narrow terms of the NHS conflict only. The change is more general and is highlighted by the support to the ambulance strike, the anti Poll Tax struggle, the recent bye-election results, the short lived opinion poll honey moon of John Major etc. More on class alliances in Part III.

16 However the empirical data in Chapter 1 do not indicate such a change.
investment is and the less the overtime hours are, etc., the better the outcome of the work is going to be. This Thesis wants to suggest that there is a relation between NHS expenditure and level of services (eg number of doctors, nurses etc.) -as cause- and the morbidity levels of the nation (expressed as days of restricted activity, and as absence form the workplace) -as effect-.

We want to address the issue that a worse funded and operated health system (not health service) ends up with a more unhealthy population. However the counter question remains: Is it a matter of coincidence without any causal relation?

The hypothesis in Part I of the thesis could had been expressed as: ‘Morbidity is an outcome of health expenditure and we believe that cutting expenditure and services will end up not to the benefit of the manufacturing bourgeoisie’.

This hypothesis stands on the assumption that health screening, maintenance, and restoration resembles a commodity since it is a product of human labour. It has the peculiarity of the absence of raw materials (unless we consider the ill person as raw material and the healthy -of restored health- a finished product). Or, to put the whole process in Marxist terms the products of human labour are but material expression of the human labour spent in their production (Marx 1967, Vol. 1, page 74) or should be seen as combination of two elements, matter and labour (ibid. p.43).

Despite the ‘absence’ (or the very strange kind) of raw material, there are both tools or instruments of production (hospitals, beds, equipment, medicines etc. in Britain owned -mostly- by the state) and labour power which exists in the living selves of the human individuals who work in the NHS (or the MHM). If the instruments of production get worse in relation to what they used to be (or more importantly in relation to their expected productive capacity) and human labour is underpaid, overworked and (subsequently) underproductive, the product/commodity is going either to be worse than it used to be or worse than it is expected to be, or it is just going to take longer to make/bring it to a low level of absence from the workplace.

Thus, we have a new ‘social policy’ claim (that health conditions of the population are related to health expenditure) which is closely related to the initial hypothesis about the contradictions of the welfare state as mentioned by Offe.

At this point we should remember both the New Right ideology against state expenditure and the ‘state’ as such and the taxation policies of the recent governments, as analysed at the first sections of Chapter 1 of Part I. Such an ideology and choice of state policies and taxation ends up ‘in the state acting against the long term interests of capital’ and proves another contradiction of the state and of the welfare state in particular. The question to be examined now becomes that of the Relation between funding the NHS and Absence.

If the relations mentioned in the previous pages stand, then the logical conclusion is that
there is a relation between health expenditure and level of absence from the workplace. However, the trends in society might not correspond exactly to the theoretical and logical -or 'mathematical'- (if 'a' has as a consequence 'b', and 'b' has as a consequence 'c', then we can assume that 'a' has as a consequence 'c' as well) presuppositions. In order to examine the validity of our presuppositions we have to apply them to empirical verification. The outcome of the application will be either the strengthening of our hypothesis or the realisation of our initial misconception and of the need to amend it. In this case we will attempt to relate the key parameters of the two previous chapters in order to examine their relation and the validity of the understanding of health care provision as a product of human labour and the attendance to the workplace as related to health expenditure.

The table (accommodating data since 1962) will relate the absence from the workplace (in the form of an aggregate average: males under 20 to 64 plus females under 20 to 59 divided by 4, million workdays per year), the days of restricted activity due to acute and chronic illness (aggregate average for individual, all entries -male, female age group, social stratum summed up and divided by 16, days) the NHS expenditure at standard prices per head of population (1962-75 at 1970 prices, the rest at 1980 ones17) and the rate of change of NHS expenditure at standard prices (percentages)

![Chart](chart.png)

**SOURCE:** "National Income and Expenditure" / "National Accounts" (the CSO 'blue book'), "Social Security Statistics" and "General Household Survey" various relevant years.

17 The data for NHS expenditure at 1980 standard prices have been divided by 5 in order to be accommodated in the graphic, as the main purpose of it is to show correlation between expenditure and absence. For a more accurate picture, see Chapter 2, Table 6.
Unfortunately the data about illness (both acute and chronic) are limited so they can not show any clear relation either to absence or to expenditure. However morbidity and absence show a very small relation which includes the sharp contrast of 1982. From our point of view though, this has to be related more to the data themselves than to an incompatibility or lack of relation between the two. Absence from the workplace is calculated and referred to by 'working days lost due to illness'. It must be borne in mind though, that in 1982 there were less working days than the previous years, due to the high level of unemployment (over 2,000,000), and on the other hand people might have been feeling too intimidated to declare ill for fear of losing their jobs. In order to approach the question more specifically the most suitable data would have been 'days lost in production due to health reasons, as a percentage of the number of working days planned (or expected) at the beginning of the year'\textsuperscript{18}.

Additionally it seems that there is a relation between morbidity and the rate of change of expenditure at standard prices. However, there is not extensive historical evidence about it due to the time limits of our data, dating from 1980 only. The indications though are worth mentioning. If we examine table 1 in a detail mentioning only the rate of change of NHS expenditure at standard prices, and the days of restricted activity due to acute and chronic sickness we have (Detail).

![Rate of Change NHS Expenditure and Morbidity](image)

**Source:** "National Income and Expenditure" / "National Accounts" (the CSO 'blue book'), and "General Household Survey" various relevant years.

\textsuperscript{18} Unfortunately such data do not exist at the Department of Employment. See Appendix for more details.
at first sight that the rate of change of NHS expenditure has been decreased since the adoption of the IMF loan in 1976, and has remained low during the years of the Thatcher administration (something we already knew from Chapter 2). While morbidity has increased after 1980 in comparison to the previous records (limited 1973-76) and is showing a steady, however slight upward trend for both acute and chronic illness, with the sole exemption of the 1988 chronic illness record19. The most important conclusion that comes out of an observation of the graphic (viz. of the relation between health policy/expenditure and morbidity) though, is the indication of the existence of an inverse relationship between the rate of change of health expenditure and the days of restricted activity, both in a short and long term. By long term we mean the differences between the mid seventies and the eighties, while by short term the differences between one year and another. This inverse relationship in the short term appears three times in the records concerning acute illness and once in the records for chronic illness. In the first case, there is a high increase in NHS spending (1975 and 76), while there is a reduction in the days of restricted activity for 1976. This pattern is followed by its reverse (cuts in expenditure, increase in morbidity) in 1980 and more clearly in 1982, while the case for chronic illness is also 1982. Moreover in all three cases the change in morbidity shows a time lag of a year. People show records of better or worse health not the very year of the change in the NHS finances, but in the following one. Such a relation cannot be just coincidental. The lack of historical/statistical data for a longer period limits us from claiming a clear and undisputable cause and effect relationship between NHS funding and morbidity. However, having four cases in about 11 years is from our point of view an indication about the relationship between the two variables, in other words about the validity of out theoretical framework. Moreover, if we take into consideration the claim about the need of a minimum increase of 1% in real terms per year for the treatment of the elderly20 and the fact that our morbidity records concern only the ages between 16 and 64 (or 60 for females), then the conclusions about an inverse relationship and a 'morbidity lag' seem valid. Finally, we would like to suggest that the relation stands on the argument raised in the previous section which examined health as an outcome of human labour. The relation between expenditure at standard prices per head of population, rate of change of expenditure at standard prices, and absence is even more clear. Apart of the data for 1982 which we dispute, we can see two cases of reduction in spending that coincide with increase in working days lost, and one case of increase in spending that coincides with decrease in absence. All these cases are

19 As mentioned earlier in the Thesis this is despite an anticipation for better records due to better nutrition, exercise, less pollution reduce smoking etc.. However, as these data and moreover their impact cannot be incorporated into our analysis and attempt to relate NHS funding to morbidity the results remain less safe and sound than we would like them to be.

20 See our quotations of C. Ham and of the Commons Select Committee in the relevant Chapters.
in periods of high employment, so the external parametre of 1982 is missing. The cases are these of 1969 (there was a reduction in spending) in real terms and in 1969 and 1970 there was an increase in the days of absence, and the same happens in the mid to late seventies and (in a lesser extent) in 1980. In both cases while the increase in absence starts the year of the cuts its peak comes the following year. It seems that the money allocated shows its results a little later (this could explain the 1983 increase in absence). On the other hand the 1974 increase and reorganisation (and the whole Castle approach) had instant -however minute- ‘response’ in a reduction of absence. It seems that there is not just a coincidence, that health expenditure relates to absence as in all cases where the ‘external factor’ (unemployment) is limited. From our point of view it is apparent that there is a relation (however loose) between health expenditure and absence from the workplace. For the phenomenon of the peak of absence coming one year later than the cuts we would like to use the term ‘expenditure/absence lag’.

On the other hand, a counter argument could be raised to the argument that a significant number of days of absence concern ‘day long’ illness and restricted activity which is out of the reach of the NHS and of the state official who will repair the productive capacity as soon as possible as Muller and Neussus claim. Such a number of days lost due to health reasons has to do with preventive medicine and personal hygiene, weather conditions, epidemics, accidents etc. As with our ‘lecturer’s example’ the case might not be even reported to the GP of the patient, or it could be reported ex post festo. The change to self certification for illness lasting less than a week in 1982 can be incorporated into these counter-arguments despite the fact that it did not produce any clear evidence of people trying to give false self-certification. We are aware that the cases of ‘day’, or ‘short’ illness, false certification, job dissatisfaction hinder a clearcut conclusion in support of our approach. However these factors have existed throughout the history of the NHS and not only in the periods we have focused upon, so their actual impact on our analysis is rather a weakening of it, than a disproof of it.

In a nutshell, it seems increasingly probable that the initial hypothesis of this Thesis that the welfare state in general and the NHS in particular is an important and integral part and function of capitalism and capitalist production, and that a possible sharp reduction in expenditure or even more abolition of the NHS would result in jeopardy of the productive capacity of economy is valid.

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21 Which could be a ‘natural’ and ‘anticipated’ spell in an adults life. In which NHS ‘repairs’ and moreover spending on the NHS could have minimal or even no impact.

22 This conclusion will be worked at Part III as well.
SECTION 3:
‘Recapitulation and Closing Remarks.’

Despite their rapid growth the PHIC remain dependent on the NHS both for the provision of 'private “pay” beds’ and because they provide an alternative and 'more convenient' service. However, the growth of the early 1980s even when matched with the concurrent shrinkage of the NHS can not be analysed as ‘privatisation’ because the private health care option remains a marginal phenomenon. In the late 1980s subscribers were less than 4% of the population, subscriptions paid for private health care insurance accounted for less than 0.5% of the GNP (albeit in a growing trend) and less than 3% of the NHS expenditure. Thus, the NHS remains the predominant agent of health maintenance, despite the assault it has faced. Additionally, the social classification and the type of subscription of the people insured by the PHIC indicates rather a top personnel fringe benefit23 than either a conscious covering of the population to the PHIC (either company or own paid) due to dissatisfaction with the NHS or a transition to post-fordism ('core' personnel only, bills met by the employer).

Discussing the second issue, this chapter has claimed that there is a relation between the rate of change of the state expenditure for the NHS and the morbidity and absence from the workplace, and has interpreted this relation by including the provision of health care in the Marxist concept of product of human labour. This claim has to be seen with some caution as the historical, empirical and statistical data available are limited covering about ten years only. On the other hand we would like to avoid overinterpreting the relation as we are aware of the complexities of health care provision24 and of the issue that some illness and absence is out of the immediate concern of the NHS25.

Additionally as it was concluded and suggested in the previous Chapters the government has failed to keep the Mode of Health Maintenance at a good level due to falling in the very contradiction of capitalism, the contradiction between the extraction of surplus value and the consolidation of the conditions for this extraction. This has been manifested by the cuts in taxation and expenditure on the level of policy and the relevant 'anti-statist' New Right rhetoric at the level of ideology26. Last but not least there are limits on the very political level because of the resistance of the working class and the reluctance of the 'middle classes' to accept changes in the Keynesian Welfare State, as argued by LeGrand and Goodin.

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23 Similar to a contribution to the mortgage, or a company car, so to attract people for the position the company wants to fill.
24 Ranging from preventive medicine and advertising 'healthier living' to operating surgery and monitoring patients.
25 Especially after the 'self certification' of 1982 (see Chapter 2). Remember our 'lecturer's example' as well.
26 See Part I, Chapter 1.
There are two matters arising from this observation in relation to our theoretical hypothesis of the British MHM since 1946.

Firstly there are the contradictions of capitalism manifested in the form of a contradiction between state and capitalism (and not just between welfare state and capitalism as Offe suggests) but in real terms being a contradiction between appropriation of surplus value and accumulation on the one hand, and keeping or maintaining the preconditions of this appropriation on the other. In other words it is the inherited contradiction between constant capital and the exploitation of variable capital by it, or the contradiction between liquidated constant capital (money) and maintenance of the productive capacity of labour. This contradiction is manifested in the NHS by on the one hand the desire for cuts in expenditure, and on the other by the limits these cuts have due to morbidity levels and the consequent absence from the workplace.

Secondly comes the issue of policy as the outcome of class struggle. Thus, if we assume that the expansion of the welfare state and the adoption of a more egalitarian MHM is a victory for the working class, then the mid seventies were a period of victory for the working class. However, the falling rate of taxation after 1976 while the Labour Party was still in office may give rise to some counter arguments to such an approach. So, we want to suggest that changes in different sectors of state policies can indicate different developments of class struggle. The working class was on the offensive and partly in command (within the limits of a capitalist economy) during the 1945-76 period. This was manifested by the period of high (or even full) employment, strong Keynesian Welfare State, the Butskellite consensus and the strength of the Trade Unions.

The bourgeois counter attack started long before Thatcherism. The first signs of it were in the mid seventies the change of the rates of taxation, as this can be the first ‘fortress’ to be captured and the easiest one. There are two reasons for taxation been the easiest target. Firstly everybody can be satisfied with some cuts in taxation, and secondly that people do not consider it a defeat since it does not take anything directly from them, and this does not put them on the defensive.

In the mid to late seventies there was a broader attack against the working class with the assistance of the IMF and this attack resulted to more cuts in the welfare state. The full scale attack was during the first years of Thatcherism manifested by monetarism.

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27 All these will be analysed in more detail in the next Part (III) of the Thesis ‘Conclusions’.

28 We would like to remind the reader of the arguments of Hirsch and Gough as well, that due to the fordist formation of economy and the subsequent division of labour and social changes society cannot reproduce itself.

29 While the abandoning of the policies of full employment and the adoption of ‘redeployment’ in 1964 can be suggested as another indication of the counter attack.
privatisation, and the (anti) Trade Union legislation. These policies though, led to high
unemployment and to general problems related with strong opposition and stability30. The
limits of these policies became rather clear in 1985 when the then Chancellor Nigel Lawson
rejected monetarism31.
These limits exist due to two reasons: a) The contradictions of capitalist economy itself as
we have claimed in the previous argument, and b) that the working class was not entirely
defeated so as to concede to whatever the bourgeois assault demanded.

Briefly, this chapter has concluded that policy is the outcome of internal
contradictions of capitalist production and of class struggle and conflict
about the mode of production, redistribution of the produced wealth and
maintenance of the productive capacity of the workforce.
It is not the limits of ideology that restricted the Conservative Governments attempts to
dismantle the Keynesian Welfare State, but the limits of implementing this ideology, ie the
contradictions of capitalism and the level of class struggle.
As far as consistency to the ideology itself is concerned the answer is twofold. First, the
Tories have tried to remain consistent to the New Right ideas of dismantling the KWS and
the NHS in particular. However, secondly, the limits of implementation of this ideology
have created a feedback in the reshaping of it (so, total privatisation of the NHS is off the
agenda and the “The No Turning Back32 group’s ideas on health are all in the paper
basket”33. Ideology itself is formed and reformed from political reality and from the key
determinants that shape policy as well.

A summary of the whole Chapter (and of the whole Part II) could be that
the changes in the National Health Service -and the whole Mode of Health
Maintenance- in the United Kingdom during the past ten years, have
indicated the contradictions of capitalist economy, the contribution of
changes in class alliances in the policies of health privatisation, and the
limits these factors can have over the success of the bourgeois offensive on
the Keynesian Welfare State. Here it is necessary to make an additional

30 The point that the Labour Party was in complete disarray over that period does not refute this claim;
rather it can help prove it. a) Opposition was expressed outside the Labour Party (see eg Brixton and
Liverpool riots) and b) the problems within the Labour Party were the result of this strong opposition
to the bourgeois assault and the inability of the Labour Party to cope with these problems by being a
working class party within the limits of a bourgeois society.
32 Group of Thatcherite Conservative MPs. They have taken their name after Mrs Thatcher once said
that “the Lady is not for turning”.
33 Anonymous Tory Source quoted by Colin Brown and Nicholas Timmins in ‘The Independent’ 5
March 1991, ‘Tories lean to Social Market’. On the other hand the existence of the ‘No Turning Back
Group’ shows consistency and conviction to a certain ideology.
point about the subtle argument of the Thesis, viz the importance of applied and empirical research for the (re)evaluation of state theory as Part II has attempted.

Part III “Conclusions” will approach these issues as questions in close relation to the theoretical claims of Part I about the importance of Reproduction for the process of capitalist production.
PART III

"CONCLUSIONS"
INTRODUCTION

The previous Parts of this Thesis raised the theoretical hypothesis and the questions that arise from this hypothesis in the light of recent political developments (Part I); and discussed these questions in a form of applied empirical research about the Mode of Health Maintenance, offering some first conclusions from this research (Part II).

In this the concluding Part III, we will bring Part I and Part II together. The objective of this Part is to examine the theoretical validity and relevance of our hypothesis in the light of empirical evidence about the developments in the NHS, the PHIC and morbidity and absence from the workplace due to health reasons.

In other words, we will re-read the theories of the ‘Capital Logic School’ (together with the ‘Contradictions’ approach of Offe) and the ‘Class Struggles’ School (placing emphasis on the Marxian origins of both), with reference and relevance to the data collected. Thus there are no new sources for this Part, as it is based on the previous two.

Part III consists of a major Chapter concluding the whole thesis and a short one reminding and highlighting the main arguments, raising some self-critical points and suggesting new areas of research in order to understand the developments in the capitalist state and the possible transition toward a ‘post-fordist’ norm of capitalism.
CHAPTER 1

"CONCLUSIONS"

Introduction.
This Thesis has examined a theoretical hypothesis according to which policy is formed by class struggles and class alliances on the one hand, and needs and contradictions of the reproduction of capitalist production on the other (in Part I, Chapter 2); and makes references to changes in class alliances in British politics during the years of the Thatcher governments (Part I, Chapter 1) and empirical data related to taxation (Part I Chapter 1), NHS expenditure and performance and the development of the Private Health Insurance Companies (Part II). This Chapter will evaluate our theoretical framework in the light of the empirical data. The Chapter will be divided into four sections, the first one dealing with the importance of class struggles and class alliances for the formation of policy making in the capitalist state; the second one dealing with the needs and contradictions of capitalist production and the third one attempting to combine the two arguments and offer some personal comments on the theoretical approaches to the state discussed in this Thesis, the fourth recapitulates the main arguments.
SECTION 1:

"Class struggles as a factor of policy making."

As mentioned in the first Part of the Thesis, there have been some important changes in British political attitudes in the past few years. Although in 1983 and 1987 the 'petit bourgeoisie', the 'middle classes' and the skilled workers electorally supported the Conservative Party, they have shown a shift in their political stances in recent years. This shift is manifested on the party political front by various opinion polls; by the short 'honeymoon period' that Mr. John Major enjoyed; by the post 1989 by-elections; and by the local elections in England and Wales (in May 1989, and 1991 -1991 local elections in Scotland also); the Euro-elections which were politically disastrous for the Conservative Party (June 1989) (see eg W. L. Miller 1990); and on the 'political activities front' by the support to the anti Poll Tax campaign, and the support for the Unions that has been shown during various disputes between them and the government, especially on the front of health care. In addition we would like to remind the reader of the traditionally strong support for the welfare state by the middle classes since they are both providers and the prime beneficiaries of these services as Goodin and LeGrand suggest in their work. Gough mentions that the growth of the welfare state "has created a new and powerful force with a vested interest in the future development of the welfare services" and he estimates their number at about 2.5 million (this was in 1979) while a considerable number of them were unionised in 1975 in NALGO (543,000), NUPE (508,000), NUT (264,000) and COHSE (143,000) about double that of the early 1960s (Gough 1979, pp. 141-142). The government response to opposition and pressure by the people was manifested by the withdrawal of a plan for the introduction of a voucher system for the provision of health care as early as 1982, and the changes of NHS expenditure as a part of the total government spending in 1984, and 1988.

1 See eg David Denver "Elections and Voting Behaviour in Britain" Hertfordshire 1989, pp. 138-139. Denver discusses the choice of party by the various socioeconomic groups. Additionally, we must not forget the ideological impact of the 1982 Falkland's war on the result of the 1983 general election, which has to be seen in conjunction with the internal problems of the opposition over that period. Voting behaviour is just a manifestation of class alliances and not a class alliance by itself.

2 Eg the monthly BBC Newsnight/Independent Polls, the BBC Poll of Polls etc.

3 Mid Standfordshire, Eastburn, Ribble Valley, Paisley South and North, Liverpool Walton; the first three being very embarrassing for the government as they were safe Conservative seats (Ribble Valley being lost after the change of party leader), while the Paisley by-elections indicate the potential challenge to the 'Unionist' parties by the Scottish National Party, and Liverpool Walton the complete domination of Mr. Kinnock over the left in the Labour Party.

4 See Part I, Chapter 1. The strikes in the NHS and the campaigns of doctors against long hours of work and the (BMA alleged) 'creeping privatisation' of the NHS are of particular interest here.

5 Gough however does not mention the BMA, which though smaller is very powerful and influential.

6 See Part I, Chapter 9, 'pie tables' mentioning share of expenditure.
From our point of view, this pressure on the government was effective due to the class alliances that were formed in its process. Contrary to the alliances of the late seventies and early eighties, in which the middle classes, the ‘petit bourgeoisie’ and (partly) the skilled workers allied with the bourgeoisie (at least electorally by voting Conservative) in order to control the power of the Trade Unions and to reduce inflation; instead they formed an alliance with the working class in support of the welfare state at first (as early as 19827) and in opposition to the entire transformation of the post war settlement later (at late 1980s, early nineties).

This state of class alliances can be described as ‘reverse Bonapartism’8, since the ‘middle classes’ have made an alliance with the proletariat, in order to defend certain interests such as the welfare state and the NHS in particular, and to counter the complete dominance of the political arena that the bourgeoisie attempted to achieve. As Marx argues in the ‘Class Struggles in France’,

“the French workers could not take a step forward, could not touch the hair of the bourgeois order, until the course of the revolution had aroused the mass of the nation, the peasants and petit bourgeois, standing between the proletariat and the bourgeoisie, against this order, against the rule of capital, and had forced them to attach themselves to the proletarians as their protagonists.” (MECW. Vol. 11, p. 57).

Or, as Gramsci puts it in “The Modern Prince”:

“given the military-dictatorial character of the head of state, such as is needed for a period of struggle for the installation and consolidation of a new form of power, the class references contained in the Art of War must be taken as referring as well to the general structure of the State: if the urban classes wish to put an end to internal disorder and external anarchy, they must base themselves on the mass of the peasants and constitute a reliable and loyal armed force of a kind totally different from the companies of fortune.” (Gramsci 1971, page 141).

The form of state desired by the bourgeoisie changes, according to the strength of this class in relation and comparison to the strength of the other classes (ibid. 142, about bourgeois support to monarchy, and Marx MECW, Vol. 11, p. 110) and on the class alliances formed, while the form of state changes with the change of class alliances (Marx, o.c. 136, and Gramsci, 1988, p. 242). While, according to Gramsci, the formation of class alliances can take the form of absorption of certain classes to other ones “it is precisely the brilliant solution of these problems which made the Risorgimento possible, in the form in which it

7 So the New Right idea for vouchers in health care provisions was so short lived.
8 See K. Marx “The Eighteenth Brumaire of Lois Bonaparte” in MECW Vol. 11, pages 109 and 110, and 194 where he mentions certain class alliances; and Part I Chapter 2 of this Thesis.
9 Italic in original, our underlining.
was achieved (and with its limitations) as ‘revolution’ without a ‘revolution’, or as ‘passive revolution’...” (Gramsci, 1988, p. 250). These alliances (and moreover the affiliations of the bourgeoisie) to certain political parties and organisations differ both in the space of time and from one country to another (Gramsci 1971, pp. 155-157), while in cases of a class equilibrium -of all forces- we might have the outcome of ‘Ceasarism’, which is a part of a hegemonic process. Gramsci believes that this ‘unifying’ role from now on does not belong to an individual hero, but to a political party.

We believe that the importance of these key arguments by Marx (in ‘The Eighteenth Brumaire’ and the ‘Class Struggles’) and Gramsci (in ‘The Modern Prince’, and various essays in the ‘Prison Notebooks’) lies not in the analysis of the particular class alliances that made the coup of L. Bonaparte possible, and the defeat of the Paris proletariat in June 1848 ‘inevitable’, but in the importance of class struggles and class alliances in the formation of policies and politics. Class alliances should be seen as a stage and element of class struggles, and the changes of class alliances is one of the most important factors that shape the form and norm of state. The concepts of ‘Bonapartism’, ‘Ceasarism’ and ‘Hegemony’ should not be approached simply as the domination of the bourgeoisie with the assistance of the petit bourgeoisie, the lumpen proletariat and the peasantry over the working class. Instead, they should be seen as the power of class struggles and class alliances and as the importance of the continuous changes of class alliances, which even hinder the bourgeoisie from adopting certain policies. We would like to suggest that a Marxist interpretation of history and politics should not be just an attempt to ‘fit’ events ‘into’ Marx’s terms and concepts. Contrary it should be the effort to use the same ‘tools’ of political analysis as Marx did and to try to analyse and understand the political developments. The cases of ‘Bonapartism’ and the ‘Defeat of June’ are only descriptions of political events and class struggles and analyses made by Marx. To make ‘Bonapartism’ an ‘instrument’ to achieve understanding of political changes is to elevate the specific political

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10 By hegemony we mean “the ability to unify and to keep unified a social group, which otherwise is not concrete and coherent by the use of ideology. As social class is hegemonic and dominant as long as it manages to keep unified a contingent of different forces, and hinders the eruption of their differences, through its political, ideological and cultural action” from Gruppi “The Concept of Hegemony in Gramsci”, our quotation from G. Paschos “ΠΟΛΙΤΙΚΗ ΔΗΜΟΚΡΑΤΙΑ ΚΑΙ ΚΟΙΝΩΝΙΚΗ ΕΞΟΥΣΙΑ” ΠΑΡΑΤΗΡΗΤΗΣ Editions Thessaloniki 1980, page 157; our translation. While Τρικούπης 1985 (p. 60) claims that the term hegemony existed before Gramsci used it in the Soviet Marxist (and in Lenin’s work) literature and Gramsci got acquainted with it during his visit to the USSR.

11 See back at Part I, Chapter 2, section 1 ‘Definitions’. However, there is very rarely any written evidence of a class alliance. The class alliances are not manifested by any forms of ‘treaties’ signed by the representatives of the respective classes. Giving evidence of a class alliance is more a matter of analysis of actions of individuals and mainly groups (either in the form of ‘grouping individuals’ by the analyst, or better- in the form of Trade unions and other pressure groups) that are (or aim to be) in support or confrontation with each other.
event to a method of analysis. The proper method of analysis should be the approach of class struggles and the changing class alliances and not the description of their certain level of development in mid nineteenth century France. Thus, we should not be looking just for a ‘Bonapartist’ state or for a ‘new hegemonic project’, or a North/South divide, but rather for the class alliances that are being attempted and developed and their results and repercussions. Politics, that is the formation of policy, is an ongoing relation of struggle concerning production and distribution of the social product and the perpetuation of this production (and relations of production) and distribution. The alliance of the British middle classes with the working class about the National Health Service was never broken, while the alliances about other forms of welfare state and state policy in general faced a number of changes in the late seventies (with the winter of discontent and the election of the Conservatives, signifying at least a ‘voting alliance’ with the bourgeoisie) and mid to late eighties (manifested by the elections of 1983 and 1987), and of course the re-alliance manifested by the opinion polls of the past two years. This reformation of class alliances, has a dual function. Firstly, the government does not have the necessary support both on the ideological and administrative level to implement the new ideas into policies (see Goodin and LeGrand on the staffing and use of the KWS), and secondly faces opposition both from these very groups who run the service, and from the whole of the political spectrum on these particular and on general policies. There is no difference whether we use the term ‘reverse Bonapartism’, or we understand Bonapartism in the broadest possible sense. The limits to the government policies about the transformation both of the welfare state (and especially the NHS) and the state in general were imposed (on the one hand) by the limits of the class alliance between the bourgeoisie and the petit bourgeoisie, the ‘middle classes’ and the skilled manual workers, and the changes of class alliances which were triggered exactly by those limits (which are the limits of the bourgeois transformation of state in the 1990s) and backfired against the Conservative government. The government might continue pursuing changes in the welfare state (and in the NHS in particular after the launching of the new Act on 1/4/91) but these changes will not be legitimised and will cause strong and mounting opposition, or -to put it in terms we have used in this chapter- will enhance and consolidate the new class (re)alliance between the (unskilled) proletariat, the skilled proletariat, the ‘middle classes’ and the ‘petit

12 For an approach to the ‘hegemonic project’ and to the ‘two nations’ theories about Thatcherism see Part 1., Chapter 2.
13 Eg. the Poll Tax, the increase of VAT, the privatisation of water and electricity etc.
14 They were imposed by the contradictions and limits of capitalism as well, see next section.
15 The fact that the changes passed through Parliament does not mean n that they are accepted by the British people. However, this is out f the research limits of the Thesis.

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bourgeoisie".  

16 The whole approach by the New Right to the policies of the welfare state can be explained (and ought to be explained) through another perspective as well. Apart from the contradiction between the two forms of industrial capital (constant vs. variable) we have to consider the occasional differences in the interests of the two forms of Capital. These are industrial and financial capital. Financial capital has not any need of long term investment altogether. (see Financial Times leading article 25/6/90). There is a strong incompatibility and clash between the two forms of Capital (see issue of the clash between CBI and City, not only on the particularity of the strong pound/sterling, but in terms of high interest rates as well). In the article mentioned above the F.T. are more 'pro City', but the problem is clearly indicated there. There have been claims (Jessop, Hall) that there was complete dominance of the 'City' during the Thatcherite years both in economic and political terms, the government following policies favourable to the financial institutions, and that these policies lead to industrial decline. But capitalism can not live without industry! Contradiction manifested in this way but much more complicated. (See next section on contradictions of capital). Such an approach relates to arguments about inter-bourgeois conflict, as a key factor of political developments. A counter argument to these approaches is offered by S. Clarke 1978. However, we believe they have some relevance to the problem of policy formation as far as they do not overemphasise the interbourgeois conflicts (which are a moment and not a component of class struggle) and they do not overlook the other aspects of class struggle, which are more important.
SECTION 2:

"The contradictions of capitalist production, as a factor of policy making."

Part I (Chapter 2) examined the changes in taxation and overall expenditure (and especially the allocation of state expenditure) in the light of the attempt of the post 1979 governments to reduce the PSBR\(^{17}\) and the money supply to economy; Part II (Chapter 1) examined the expenditure and the policy changes regarding the NHS in more detail and their results as far as morbidity and absence from the workplace is concerned. In the concluding Chapter of Part II, we argued that there is indication of some correlation between the cuts (and in one case the increase) in health expenditure and the absence from the workplace due to health reasons the following year. In this section we will relate the conclusions of Part II to our theoretical hypothesis analysed in Chapters 1 and 3 of Part I.

While we agree with the analysis of the welfare state by the Capital Logic school as a theory explaining the creation of the welfare state and the limitations of the cuts and changes in the welfare state out of inherent needs of capitalist production (either needs of reproduction themselves or the inability and incapacity of the fordist society to reproduce itself), we think that such an analysis is inadequate as an explanation of both the changes of the welfare state (in a lesser extent\(^{18}\)), and (mainly) the 'desire' and need of capital for such changes This inadequacy of the Capitalist Logic School (here in the 'narrow sense' without Offe) is caused by overlooking the contradictions of capitalist production as explained by Offe. Additionally, Muller and Neussus (the two theorists with an approach most relevant to our area of interest) neglect the issue of class struggles and of the contribution that class struggles can have on the formation of policy. Anyway, the main shortcoming of the School of German Derivation is in our view that although it attempts to examine the needs of capitalist production and to 'derive' the state and the state policies out of these needs, it fails to see that these needs are contradictory, due to contradiction of capitalist economy as we claimed in the previous Parts of this Thesis.

So the contradiction\(^{19}\) in a fetished form seems to lie in the two functions of the agent who lives in a bourgeois society. As citoyen s/he does not want to pay taxes. In this level s/he wants (or at least the New Right theorists tell us that s/he wants\(^{19}\)) to pay very low taxes.

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\(^{17}\) Public Spending Borrowing Requirement: this is the outcome of a deduction between state revenue, less state expenditure.

\(^{18}\) See our reference to C. Offe 'The Contradictions of the Welfare State' in Chapter 2 of Part I.

\(^{19}\) However, the various opinion polls of the sixties people wanted to pay higher taxes in order to have a better welfare state.
As bourgeois though, s/he needs to invest on the reproduction of the productive capacity of his workforce. Since this investment is not always profitable it has to be undertaken by ‘someone’ who does not care about profitability of investment.

By trying to reduce taxes and state expenditure especially the part of expenditure that we understand as contribution to reproduction, the post 1979 governments failed to distinguish between citoyen and bourgeois. The Conservatives, while in office by trying to help the Tax Payer-citoyen, who looks after his/her narrow self interest are causing problems to the economic active bourgeois who needs the help/assistance of the state for securing reproduction of the productive capacity of the workforce. Clarke in his “Keynesianism, Monetarism and the Crisis of the State” (1988) addresses this problem accurately:

“The contradictions of Keynesianism, were ultimately of an expression of the contradictions of the capitalist state form as the growing pressure for accumulation did not appear immediately as such, but rather appeared as the form of an economic, political and ideological crisis of the Keynesian Welfare State. Thus, the limits of Keynesianism did not mark the limits of capitalism, nor even the limits of fiscal regulation, but the limits of the Keynesian political strategy of sponsored class collaboration, on the basis of full employment and a generalised expectation of rising living standards, within a framework of the liberal state form.” (Clarke 1988, p. 304)

As reproduction is not profitable and does not offer safe extraction of surplus labour and surplus value, no capitalist wants to invest heavily in it. As we saw in the analysis of the tenth Chapter of the First volume of Capital, the capitalists had in the nineteenth century (and still have due to their greed to maximise profits) an ‘apres moi la deluge’ attitude towards the needs of their workforce.

So, the agent who stands outside and alongside society and whose task is to create condition favourable for capital accumulation (Miliband) has to take action to secure reproduction, which is essential for the continuation of the extraction of surplus labour and surplus value. In other words, the needs of ‘capitalism in general’ are different to and conflicting with the needs of each individual capitalist.

The first steps towards a solution of the problem is given by the theory of the ‘contradictions of the welfare state’ by Offe and Gough (Gough in a slightly different

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20 ‘Reproduction’ in this section stands for ‘reproduction of the productive capacity of the workforce as such’ as analysed in Part I, Chapter 2.
21 See our references to Muller and Neussus and O’Connor in Part I, Chapter 2.
22 See Karl Marx, “On the Jewish Question”, MECW Vol.3
23 However, Clarke focuses on the issue of class struggles and neglects the needs and contradictions of capital.
24 Especially after its ‘nationalisation’ in Britain after the second world war, as seen in Chapter 2 of Part I.
25 Which apparently is the one side of the contradiction.
approach, which is however fuller as it addresses class struggles as well).
In this concluding Chapter, we would like to suggest that our treatment of the case study of
the MHM and our general reference to British politics have made this contradiction
apparent but have indicated the incapacities of these theories also. Our view is that Offe’s
and Gough’s mistake is that they see the existence of a contradiction only in the policies of
the welfare state “the contradiction is that capitalism cannot coexist with, neither can it exist
without, the welfare state” (Offe, 1984, p. 153). From our point of view the reason for the contradictions of the welfare state lies in the
contradiction between extraction of surplus value and securing the extraction of surplus
value, and is manifested through the contradictions of the agent in capitalist society between
the two functions of bourgeois and citoyen. We will approach this argument in more detail
in the course of this chapter. As an additional point of critique, we want to argue that Offe
does limit his analysis to the welfare state, while from our point of view such an
approach stands for the state as a whole. The policies of the state are contradictory
by themselves whether they are trying to secure reproduction of the productive capacity of
the workforce, or the subordination of the workforce itself, or the security of the constant
capital against external or internal dangers. As argued in the theoretical Chapters of Part I,
these functions are to be undertaken by the state since they do not produce surplus value (or
are perceived as public utilities), although they secure the basis for extraction of surplus
value by capital. But in order to be accomplished they need to be:
a) Financed presumably by the capitalist (at this point the level of class struggle is going to
influence the decision) and to a lesser extent, able to reduce the number of workers
available for exploitation and
b) To regulate certain functions of capital as far as valorisation and accumulation are
concerned (eg the length of the working day, quality of products, safety at the workplace
e.g.).
Our argument is that the contradiction of the capitalist societies is that, capitalism cannot thrive under the state, but it will collapse without it.
As far as the more narrow focus for the purposes of our research thesis is concerned, and
for the question of reproduction, we would like to mention that though the analysis is
sound as such, Offe does not go far enough in his analysis of the contradictions of the state
and of the welfare state in particular. He mentions only the contradictions themselves, while

26 See Part II, Chapter 3, where we compare the rate of change of NHS expenditure at standard prices
with morbidity and absence from the workplace and we claim that there is a form of a reverse analogy
between the two.
27 See Part I, Chapter 1.
28 Obviously this argument should be verified by applied empirical research; for the time being it
remains open for future case studies.
he does not examine the reasons for these contradictions. The answer to this problem can be given by returning to classical Marxism, and by relating the analysis of wages that Marx offers in ‘Capital’, the value of labour power is the cost of its (re)production then the welfare state is a form of wage 29 to the problems of modern capitalism and fordism. However the cost of reproduction of the productive capacity of the workforce cannot always take monetary form and be given to the individual worker because of both the division of labour and specialisation on the one hand and the expectations (of the working class) of a standard of living (including health care, pensions, schooling for the offspring etc.) on the other make self reproduction -at least in fordism 30- difficult.

The question in a general approach stands as: who is to pay for reproduction? 31

To express this question in Marxist terms we have to say: “is reproduction going to be paid for by variable capital ‘through’ (and in legal terms ‘by’) the worker, or by constant capital and/or surplus value (or in ‘legal’ terms by/through the welfare state financed through taxation 32)?”

The main aim of capitalist production is the enlargement of the invested capital, [symbolised here as M(oney)] and its re-investment, circulation in capitalism aims at (and becomes), M-C(ommodity)-M’. where M’>M.

According to Marx, capital consists of two part ‘constant capital’ (c) and ‘variable capital’ (v) or,

\[ C(\text{apital}) = c+v, \]

and during capitalist production ‘variable capital’ undertakes an expansion of its value, creating an additional ‘surplus value’ (s) or,

\[ C(\text{apital}') = c+v+s. 33 \]

Thus, the question ‘who to pay for reproduction’, can be expressed in another way: “Will reproduction be paid through ‘constant capital’, ‘variable capital’, or ‘surplus value’?”. As seen earlier, the answer depends on the development of society, specialties, expectations (Gough and Hirsch) and class struggle and legitimacy (LeGrand -in ‘behaviourist’ school-, Marx -‘Eighteenth Brumaire’, ‘Civil War’-, and Gramsci).

In fordism reproduction has to be paid chiefly by the capitalist in the form of investment of

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29 See Part I, Chapter 2, section ‘Definitions’ as well.
30 See our reference to J. Hirsch and Ian Gough in Chapter 1 of Part I, about the division of labour and specialties in the ‘fordist’ society that hinder its self (and without external assistance) reproduction.
31 See the relevant section of Chapter 1 of Part I as well.
32 At this point we should be aware of the changing patterns of taxation and state revenue. Flat rate taxes and consumption-indirect taxes have increased in the previous years, while rates of income tax have been decreased, thus the less well off pay proportionally more taxes. See O’Connor 1973, p. 206, on corporate and personal taxation, and (for a critique to O’Connor) later on in this Chapter.
33 See K. Marx ‘Capital’ Vol. 1, pp. 155ff, 186ff, and 212ff in particular.
surplus value through taxation and the KWS\textsuperscript{34}. This creates the contradiction between extraction of surplus value and securing the conditions for the perpetuation of extraction (to which we referred earlier and which is manifested by the indication of an inverse analogy between rate of change NHS expenditure and morbidity and absence\textsuperscript{35}) and in capitalist logical and audit terms it is a contradiction between taxation-welfare (investment on the productive capacity of the workforce) and investment on equipment ie constant capital. In other words it is the contradiction between dead and living labour (see Capital Vol. 1, p. 233).

So this part of the cost of the labour power has to be paid by the capitalist (this depends on class struggle, and on legitimacy problems -see previous section). The question now becomes whether the cost will be paid in a form of variable capital, or in form of investment of surplus value extracted. The question expressed this way is only sequential.

The more proper way to express the question is whether the extracted surplus value will be used as investment on ‘machinery’ (or means of production), or as investment on securing reproduction through the (welfare) state\textsuperscript{36}. Thus, the conflict/contradiction is between expansion of constant capital and securing the profitability of this expansion (viz. to maintain the productive capacity -and subordination- of the workforce). In other words is the fight between dead and living labour\textsuperscript{37}.

As mentioned earlier the relation between surplus value and constant capital is only sequential, while in real terms the issue is the contradiction between extraction of surplus value and expansion of this extraction on the one hand, versus securing of this extraction of surplus value on the other.

This argument can be seen as another contradiction between constant and variable capital. The cost of the maintenance and reproduction of the variable capital is very high for the constant one, and obstructs its expansion. So, the clash is not between state and individual (as the New Right ideologists claim), but between the dual and inherently contradictory function of the person in capitalist society (bourgeois and citoyen) on the one hand and the contradiction between the needs of expansion of the constant capital (re-investment) and the needs of maintenance and reproduction of the productive capacity of the human labour part of the variable capital on the other. The contradiction between the two functions of the person who lives in bourgeois society (bourgeois vs. citoyen) is a consequence of the

\textsuperscript{34} For additional reasons see, O’Connor on buying surplus product using surplus value.

\textsuperscript{35} See Part II, Chapter 3.

\textsuperscript{36} A third way to use surplus value for the capitalist is to buy either necessities of luxuries; in other words to buy the product of surplus labour, and avoid a crisis of underconsumption. Since capitalism is not simply the pursuit of profit and leisure we will not deal with this case. See O’Connor 1973 about the key function of the state to buy the product of surplus labour.

contradiction between the basic contradiction, which is the contradiction between extraction of surplus value and securing this extraction, or in Marx's terms between 'dead and living labour'. Thus, the conflict about increased taxation and state expenditure on welfare projects, is not a contradiction between capitalism and the state (as New Right theories claim), but an inherent and intrinsic contradiction of capitalism itself.

However, as we have observed in Part II, Chapter 2 (and in a lesser extent Chapter 3) there has been a shift, however minimal, towards private health insurance especially as far the as 'key' personnel of companies is concerned. Although there is not adequate evidence supporting the claim of such a shift for the skilled manual workers in the new automated ('post-fordist') industries\(^{38}\), it seems that there is a growing trend and tendency toward insuring the 'core workers' at the PHIC as a part of their wage package. This, if matched by tax reductions and deterioration of the NHS might provide cheaper maintenance of the productive capacity of the workforce, because it would be only the productive capacity of the 'key' 'core' 'flexible' workforce that will matter. Expressing this trend in terms of our Thesis, reads as "in post-fordism the reproduction of the productive capacity of the (key) workforce is secured through the investment of constant capital, or through a combination of constant capital and variable capital\(^{39}\), while Health Maintenance is provided by the Private Health Insurance Companies\(^{40}\).

Examining the question of reproduction in this way, there is very little difference between 'fordism' and 'post-fordism'\(^{41}\). What changes is the 'providing agent' i.e in 'post-fordism' it is the PHIC instead of the state.

**But even in the case of post fordist and payment of reproduction of the core**

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\(^{38}\) In the CSO publications these workers are mentioned as social group C2, without any further differentiation according to skill ('fordist' or 'post-fordist'). This creates a first set of problems as far as such an analysis is concerned. The main problem tough is that the PHIC and the TUC were unwilling to disclose relevant information, the DTI, DoH, DoE, and the CBI answered that they had no information on the matter. See relevant Chapters of Part II, and Appendix 'Letters and Replies' attached at the end of the Thesis.

\(^{39}\) Capitalist and worker expenditure, (proportionate combination in sharing the cost). See footnote 4:2 as well.

\(^{40}\) Additionally though, there might be limits imposed by class struggle and class alliances and a feedback of ideology 'health for all', 'egalitarianism' etc.

\(^{41}\) At this point we want to mention our agreement with Psychopedis (1991) about the descriptive and not analytical value of the term 'fordism' and 'post-fordism'. From our point of view using 'fordism' and 'post-fordism' as analytical and not descriptive terms we are falling in quite the same mistake as when using 'Bonapartism' as an analytical term. It is a case of elevating a historical contingent case (mass production of standardised commodities in assembly line, organised factories requiring semi-skilled work) to a method of analysis. The method of analysis should be the examination of the relations of production and of their relation to the state. 'Fordism' is a description of a certain stage in the development of industrial relations etc. and not a method of analysis, as we mention earlier about Bonapartism and class alliances.
workforce through PHIC (and Private pensions schemes, private schooling and training etc.) the contradiction between expansion and securing remains. It only takes different manifestations and forms. It has already ended up as a ‘market’ clash between ‘high’ prices set by the PHIC that the ‘buyers’ (capitalists that want to ‘insure/secure’ their workforce -and its productive capacity-) cannot afford. However, this is in an embryonic stage as yet.

O’Connor (1973, p. 206), misses exactly this point falling to the error of elevating a historic/contingent way of payment for reproduction dependent on class struggles to a ‘rule’ and contradiction of capitalism. He refers to the contradictions of taxation and to the preference and pressure by companies’ shareholders to be taxed on their corporate income (so they can increase prices and the working class will have to pay) instead of personal income. Consequently, according to O’Connor, tax burden falls on the working class, but working class requires high expenditure for its reproduction. O’Connor mentions another solution to ‘who should pay for reproduction’, which is (as discussed in the previous section) an issue dependent on the level of class struggle and class alliances, thus his use of the term ‘contradiction’ is not justified in this case. The contradiction is still between extraction of surplus value and securing the perpetuation of extraction of surplus value and not (as O’Connor claims, due to its manifestation in the United States during that period) between the high cost of reproduction and what the working class can afford, when this cost is transformed to prices of goods in the market due to corporate taxation.

42 Unless we use Bonefeld’s (see Bonefeld 1987/1991) claim that in post-fordism the Trades Unions work like service associations (eg the Automobile Association) offering services to their -selected- members (this argument mentioned by Murray also). However, such an approach provides us with a theoretical difficulty as the workers will be paying for reproduction (through their Unions’ subscription) instead of the employers. In other words, according to Bonefeld’s description of ‘post-fordism’ reproduction is paid by variable capital and not by surplus value. This resets the whole issue of contradictions etc. For the time being though, there is no evidence of such a transition.

43 At least as far as our use of the terms ‘contradiction’ and ‘reproduction’ are concerned.
SECTION 3.

"Combining the two arguments."

This Chapter has offered two seemingly different arguments (firstly that policies are the outcome of class struggles and alliances; and secondly that policies are the outcome of the contradictory needs of capitalist production) for the explanation of the development of health policies in Britain during the Thatcher governments, and has suggested that both these arguments can and should be used as the main methods of analysis for approaching and analysing all capitalist societies. These two arguments have to be seen in combination. They are not in conflict with each other, and they do not exclude each other. Capital logic theories (German derivation and French Regulation) lack an understanding of the importance of class struggles and tend to become functionalist and reduce their dialectical and holistic character. Policies become simply the outcome of needs (and contradictions) of capitalist production, as if the only limitation to the needs of capitalist production and exploitation being its contradictions. But if we reintroduce the class struggle element (especially in the form of changing class alliances) we can see the limits to the expectations of capital.

On the other hand class struggle theories lack the very framework in which to operate as they do not see the contradictory needs of capitalist production. In addition some of the class struggle theories (Jessop, Hall -in his ‘hegemonic project’ analysis) overemphasise the ‘parable’ of basis and superstructure and lack a dialectic reasoning since they fail to explain what the relation between basis and superstructure is (Jessop), and see class struggles as the imposition of the will of the bourgeois class (Hall in his hegemonic project) becoming deterministic and partly functionalist (the bourgeois class ‘functionally’ needs these alliances/hegemony and achieves them). The critique raised by Bonefeld, Clarke and Holloway addresses this problem properly. Bonefeld, Clarke and Holloway correctly mention the strength of the working class as a hindrance to the entire imposition of the will of the bourgeoisie, and properly analyse (especially Holloway) the class struggles as subtle and not noisy but ever going. However, they do not express any particular interest in

44 Used by Marx in the 'Eighteenth Brumaire'.

45 Additionally, Gough 1979 argues about the importance of class struggles in the formation of policies mentioning class struggles as an contradiction of capitalism. As Gough’s work precedes the work of Hall and Jessop we do not include him to the critics. On the other hand though, he should be included to the critics of the German Derivation (and Capital Logic School) as he argues about the importance of class struggles in the formation of policies.
possible class alliances and their changes as a factor of formation of policies. The main mistake of Bonefeld, Clarke and Holloway though, is that they do not examine the intrinsic and inherent needs and contradictions of capitalism. In their opposition to the ‘Capital Logic School’ as deterministic they fail to see (Bonefeld in his ‘Reformulation’ article in particular) that capitalism has needs because of its structure and that these needs are contradictory, so the policies deriving out of those needs are contradictory too.

By combining and amalgamating these two arguments in a unified approach, we are able to create a new method of analysis and of understanding the policies of the state, and consequently the state as a whole.

From our approach to the British Mode of Health Maintenance and its changes between 1945 and 1989, and between 1979 and 89 in particular we would like to conclude that:

The state is a class relation which the outcome of The Class Relation (viz. of the aggregate and amalgamation of all class relations within society) and can be understood and approached using as starting point its policies which are the results of the needs of capital accumulation and valorisation, the contradictions of this accumulation and valorisation (ie the contradiction between extraction of surplus value and perpetuation of this extraction cf. Offe and previous argument) and working class resistance to the process of accumulation and valorisation, in conjunction with claims about distribution of the product, which are raised by the ‘other classes’ as well. viz. class struggles and class alliances.

Thus, the (capitalist) state being the aggregate and the outcome of all class relations within

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46 While our approach to Goodin and LeGrand, and relating their argument to Marx’s ‘historical writings’ and Gramsci on a theory level, and the mentioning of ‘the summer of discontent’ the support of the ambulancemen strike, the various by-elections local elections the Euro-elections and the changes of political stances as manifested at the opinion polls indicate such changes. Especially the strong (re)alliance around the KWS and the NHS are strong indications of the importance of such class alliances.

47 As we claim with the comparison of taxation, NHS expenditure and control on the one hand and morbidity absence from the workplace (thus reduced productive) on the other in the first two Parts of this thesis. As Chapter 3 of Part II indicates health restoration (ie the restoration of the productive capacity of the workforce) is expensive for capital, but its absence can potentially be even more expensive.

48 From such an approach the question between combination and relation arises; is class struggle dependent on the contradictions of capitalist production, or vice versa? We believe that the cause and effect relation between class struggle and contradictions of capitalist production depends on each particular policy. Eg securing subordination of the workforce (or reproduction as such) and its cost depends (the cost on class struggle and militancy). But reproduction of healthy workforce depends on other reasons. All reasons though, interact and feedback (with) each other.

49 As Jessop 1982 mentions the reasons for the different ways Marxist theory of the state developed in (different countries in) Europe, were “in short, while strong traditions of working class industrial and political struggle in such countries as Italy and France have favoured a class-theoretical analysis of the economy and state alike, West German Marxists were encouraged to consider them from a more ‘capital-theoretical’ perspective...” (p.79).

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capitalist economy and of the needs and contradictions of capitalism is inherently contradictory since all relations within capitalist society are contradictory.

This Chapter raised two separate critiques of the ‘Capital Logic’ school (and of the ‘Structuralist School’ in a lesser extent), and of the Critique (by Bonefeld, Clarke and Holloway) of the ‘Capital Logic’ and ‘Structuralist’ Schools (main part of the second critique) for either not taking adequate care of class struggles in the understanding of the formation of policy, or for lacking a general framework of capitalist production and a causal relation between ‘basis’ and ‘superstructure’. On a theory level we would like to claim that the inadequacy of each of the contemporary Marxist approaches has been caused by overemphasising on one of the two arguments Marx himself uses to analyse capitalist economy. Both capitalist needs and contradiction and class struggles exist in Marx’s approaches and we believe that Marx does not give any predominance to either the one or the other. Thus, we believe that a return to classical Marxist writings (mainly the ‘1844 Manuscripts’, the ‘German Ideology’, the ‘Jewish Question’, the ‘Capital’, the ‘Eighteenth Brumaire’ and the ‘Civil War’) and their application to current politics and policies and the results and repercussions of these policies and politics, through the understanding of the modern capitalist state by contemporary scholars, as the form and norm of capitalism have changed, could provide us with a proper understanding of the state. This quest for applied and empirical research leads to our third point of critique of the current Marxist schools.

This third critique to these two (or three) mainstream Marxist understandings of the state is their lack of sufficient empirical foundation and backing. This whole Thesis has approached and analysed a certain set of policies, vital for capitalist economy such as the Mode of Health Maintenance and attempted deriving an understanding of politics and the contemporary capitalist state from it. It is our view that the best way to approach the state is through its manifestations, ie through state policies. At this point we are in full agreement with R. Miliband (‘The Capitalist State. A Reply to Nicos Poulanzas’ NLR, 59, Jan.-Feb. 1970) who claims that the study of the concrete is essential for the understanding of politics, and that there is a necessity for empirically proving (or disproving) our theoretical presuppositions. We would go even a step further and claim that empirical research is essential not only for proving, or disproving, our theoretical understanding of politics and the state, but for their very construction as well. Neither Capital Logic, Structuralist school nor the critique raised by Bonefeld, Clarke and Holloway, attempt an analysis of the concrete towards an understanding of the state. The only contributions that move in this direction are those of O’Connor (1973) and Aglietta (1979), who fail to give an

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50 Taking care that the focusing on the health policies would not end up in an exclusion of the rest state policies from our understanding of the development of the state in the 1979-89 period as a whole. See Chapter 1 of Part I, and the various references against ‘monistic’ approaches to politics throughout the thesis.
understanding of the state and politics at the end of their work, giving mainly valuable comments on political developments (mainly in the form of taxation and expenditure), and Holloway (1987) who we think overemphasises the data available to him in his research about the British motor industry. Moreover (as we mention earlier), he remains very much within a class struggles argument, mentioning only the need to control and the ‘right to manage’ for both state and capital, while he once more overlooks the intrinsic needs and contradictions of capitalist production and reproduction. Additionally, he does not see that these contradictions exist even in the quest of the ‘right to manage’, as cost of control of the labour power and as cost of the transformation of industry and industrial relations in order to achieve it. In the ‘Red Rose’, Holloway sees the relation between the state and capital in the abstract:

“If changes in the car industry are representative of changes in the pattern of management-labour relations more generally, then it is not surprising that there are parallels between changes in managerial style and changes in the state. The parallel development of management and the state has been presented here in the form of an analogy, but the similarities are not a matter of chance. Management and the state are two aspects of the same thing, they are two forms of the capital relation, the relation of domination between capital and labour.” (ms. pp. 29-30).

Such an approach has a number of problems. Firstly, as we have just argued it overlooks the needs and contradictions of capitalism. Secondly, the relation between capitalism and the state remains weak, reduced to an understanding of common needs, and thirdly, the case study and empirical evidence are not adequate to support such a broad claim. Though we agree with this argument, we believe it is not adequate to explain developments in the modern state and the modern state itself, as it does not mention the relationship between capitalism and state, stopping only in their common objectives. It neglects the state functions that assist capital such as reproduction in the broad sense (including education and training), and the buying of surplus labour by surplus value (which is the state’s income as Holloway himself admits) as O’Connor (1973) claims. Last, but not least the article lacks strong empirical evidence. There is no analysis of Trade Unions Laws and their impact, while all the evidence relies on secondary sources. This is more a study of the opinion of people (sometimes of the actors themselves) about the events and not an approach to circumstantial evidence itself. Though ‘in principle’ we are very close to

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51 This critique is related to our claim about the contradiction between capitalism and the state and not a contradiction between capitalism and the welfare state only as Offe claims.

52 Eg. Craig Luther and Graeme Salamon in their “Design of Jobs” 1984 make more reference to work practices.
Holloway’s point (however only in his essay ‘The Red Rose of Nissan’, 1987)\textsuperscript{53}, we think that his mistake is one of overanalysis out of just one development in industry (and not in state policies), especially so long as this transition of industry to a ‘post-fordist’ form has not been completed yet. Moreover, Holloway’s work has very little empirical backing as far as the particular and concrete issue he wants to discuss (both the Nissan factory in Sunderland, and the British motor industry as a whole) is concerned. While our difference with the ‘Capital Logic’ school and the ‘Structuralist Abstractionist School’\textsuperscript{54} and of the rest of the work by Bonefeld, Clarke and Holloway, is one of method since they avoid concrete research and empirical backing, our difference with Holloway (1987 only) is one of emphasis. We think that the concrete case study should be something more central to the whole development of the state than the on-going transformation of industrial relations in one section of industry, that there is a need for better empirical evidence and backing, and finally that these changes indicate aspects of the state and cannot be used as universal rules and explanations.

\textsuperscript{53} Such a critique stands for most of Holloway’s and Bonefeld’s work. We concentrate on the Red Rose because of the inadequacy (and not the absolute lack) of empirical evidence.

\textsuperscript{54} Term coined by Miliband (NLR 82, Nov., Dec. 1973) to criticise Poulanzas and Althusser.
Section 4

"Recapitulation of main arguments".

Completing this work, we would like to recall our main arguments.

a) The policies of the welfare state (and the state itself) are the outcome of both inherent needs and contradictions of capitalist production and class struggles and class alliances. These contradictions of capitalism are the outcome of its very needs. They are the contradiction between extracting surplus value and expanding the extraction of surplus value (and reinvesting it) on the one hand, and securing and perpetuating this extraction of surplus value on the other. The cost of the latter is a hindrance for the former, which in capitalist audit terms is manifested as a hindrance to accumulation and as high taxation. Additionally, the resistance of the working class to its exploitation should not be overlooked, as it can cause new hindrances to the process of accumulation. Moreover, the reaction of the working class should not be examined in isolation from other political events and of the actions and activities of the "other classes". The other classes form their alliances with either the bourgeoisie or the proletariat depending on hopes and prospects (e.g. the creation of the welfare state in the 1940s) or on fears and anxieties about vested interests and ideological conceptions (the resistance to changes in the late 1980s). We believe that the theoretical framework for such an approach exists in classical Marxism, while the contemporary Marxist schools are mistaken in overemphasising one or the other element and overlooking the other.

b) Additionally, this Thesis has claimed the validity and importance of applied research and approach of concrete policies in the pursuit of political understanding, and its compatibility with a Marxist theoretical framework. From our point of view state theory cannot be conceived divorced from an analysis of the state itself and its policies. We believe that in the quest of an understanding of capitalism and the state, it is necessary to approach and analyse the concrete and the manifestation of the state, in other words the various policies the state pursues and their repercussions. Such an approach will help to the critical evaluation of our theoretical framework and presuppositions.

The next (and last) Chapter of the Thesis will re-approach the main empirical findings of the Thesis and their limitations raising some self-critical points.
CHAPTER 2

“EPILOGUE”

A) A Brief Summary.

This Thesis has examined the formation and results of a particular set of policies regarding the maintenance of the productive capacity of the workforce (the MHM) and has concluded on these policies and offered a possible understanding of the capitalist state as the outcome of needs and contradictions of capitalism and class struggles without giving any of these factors any predominance over the others.

From our point of view the main finding of this research is portrayed in the table of Chapter 3 of Part II which relates the rate of change of NHS expenditure at standard prices to morbidity and absence from the workplace due to health reasons. Such an approach gives some form of empirical evidence to the Capital Logic theories especially to the approach of the state, the welfare state, and the health services by Muller and Neussus (in Holloway, Picciotto 1979), and certainly to Offe and Gough about the ‘contradictions of the welfare state’ these contradictions being between its cost and its contribution (or as we claim between the extraction of surplus value and the perpetuation of this extraction).

The second important empirical finding of our research relates to the process of ‘health privatisation’. We claimed that the PHIC are dependent on the NHS and on the state in general for their performance, as they grow or shrink in an inverse way to the NHS (eg the years 1975-76 for growth of the NHS and shrinkage of the PHIC and 1982 for the opposite) not only in expenditure terms but in function terms also (1976 abolition of pay beds, 1980 reintroduction and new consultant contract, plus the impact of the ‘winter of discontent’ 1979), and to state policies such as tax exemptions (letter by D. Damerel of BUPA to the Times). Additionally in the discussion of health care this thesis did not find any convincing evidence about the existence of a post fordist health care system, while we suggested that private health care coverage remains mainly a fringe benefit in order to attract ‘top’ employees at the ‘key’ positions of the companies rather than, a rational pursuit to secure reproduction and maintenance of the productive capacity of the ‘core’ workers, and dissatisfaction with the NHS.

In the previous Chapter we argued that the claim about the contradictions of the welfare state stands for the state as a whole as all policies of the state contribute to the securing of
extraction of surplus value, while these policies were concurrently a hindrance of such an extraction and capital accumulation.

The last main point this thesis has raised is the subtle methodological answer to the question of how to approach politics and state theory. The ‘post-Miliband-ian’ analysis this thesis has undertaken is in our view a sound way of (re)evaluating, (re)creating and (re)shaping our understanding of the state. The study of certain and specific sectors of state and state policies and their relation to developments in the economic process can assist us in achieving a clear understanding of the state phenomenon and its development.

B) The Limits of our Analysis and Arguments.

The limits of our analysis and arguments are based on our ‘subtle methodological approach’. As mentioned in the relevant chapters of this research, in many cases it was difficult or even impossible to compile data and information, as these data either did not exist (eg. the percentage of days lost due to illness instead of their aggregate number), or were 'commercially sensitive' (eg the percentage of C2s insured by their employers as a part of the wage package). Additionally, in many cases 'illness' is such that it remains outside the capacity of the MHM to restore ‘timely’ (eg day illness), while there is a increase of the days of work lost ‘due to acute health reasons’. As we mentioned in the chapter about the adequacy of our data, on top of these inadequacies come the organisation of work of the GP him/herself, the issues of job (dis)satisfaction and the use of ‘health reasons’ as an excuse for evading work, the contribution better nutrition and housing (and the reduction of smoking and pollution) can have to human health etc. Unfortunately, it is not possible to incorporate all these factors and their contribution in a clear and undisputable way. This makes an undisputable and 100% correlation between state expenditure in health (not to mention the allocation of this expenditure itself) and absence from the workplace impossible. This is why we claim that the Graphic comparison in Chapter 3 of Part II is an indication of an inverse relationship between state expenditure in health and morbidity and absence from the workplace, but not absolute proof of it. Such a lack of evidence stands for the transition to a ‘post-fordist’ form of capitalism and society also, as mentioned in Chapter 2 of Part II for the MHM. Moreover such a claim deriving from findings of research in one sector have to be compared and corroborated with evidence from other sectors of state policy. For example in order to be able to support a theory about transition to ‘post-fordism’ we would not need only evidence of a two tier health maintenance system (as described earlier), but evidence of changing in housing habits and opportunities (eg ‘core’ workers buying their homes -possibly with some assistance by their employer- or being housed by the employer, while ‘peripheral’ ones living in derelict council houses), pensions (again ‘core’ -private- vs. ‘peripheral’ state and

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low), training of the workers him/her self (retraining) or the of offspring (different opportunities for ‘core’ -company assisted- and for ‘peripheral’) etc. Cases with potential for discussion and examination are numerous and such a research project is far beyond the limits of a project to be undertaken by one individual. The second cause of problems of such a research is the possible (un)availability of data either to prove or to disprove a hypothesis, as this Thesis faced with the PHIC and the insuring of the ‘core’ workers.

This broader research should be applied in our argument that ‘capitalism cannot thrive under the state but it will collapse without it’ also. The claim remains unsafe as lacking empirical evidence before applied research on state policies assisting reproduction (housing, education, training, child benefits etc.), subordination of the workforce (trade unions legislation, policing, law and order, defence and education), regulation of production (working hours, safety at the workplace, environment), and safety of the invested capital (international monetary policies, defence) to mention the most important is undertaken.

As with our critique to Holloway’s ‘Red Rose’ (1987) the single and simple analysis of one area or sector of state activity (or indeed in-activity) might be inadequate to explain the state as a whole and can be alleged of ‘overanalysis’. In this case the conclusions can mention only “possible and probable trends and tendencies towards...” and as we say in the relevant Chapter leave the issue open for the historian and the political scientist of the future. Anyhow, these issues remain open (and invite us) for further research under the ‘post-Miliband-ian’ method that we suggest.

In a nutshell, this Thesis has not managed to give undeniable and unchallengeable proof of our theoretical hypothesis about the relationship between state expenditure on the Mode of Health Maintenance and the level of absenteeism from the workplace due to health reasons; neither about a possible transition towards a post-fordist society. It has produced just some considerable indications in evidence of the first theoretical claim. And it is poetry, not social sciences, that can recapitulate in two sentences:

“When you start on your journey to Ithaca,
then pray that the road is long,
full of adventure, full of knowledge.

..........................................................

And if you find her poor, Ithaca has not defrauded you.
With the great wisdom you have gained, with so much experience,
you must surely have understood by then what Ithacas mean”

(From K. Kavaphes “Ithaca” transalated by Rae Dalven).

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APPENDIX

In this appendix we have included our correspondence with the various organisations and offices we approached in our quest for data, especially for the private health care subscriptions of the semi-skilled manual workers (classification C2); and for the days of absence from the workplace due to ill health, as a proportion of the anticipated workdays of the whole statistical year.
Edinburgh, 17/12/1990

Dear Sirs,

I am a postgraduate student pursuing research on the British health services, and on the private provision of health care in particular. I am very interested in the case of private health care provision for the skilled manual workers (classified by the Central Statistical Office as C2) in automated industries. My main interest is examining the case of workers whose subscription is paid by employers in addition to their monetary wage. The focus of the research is post 1979, but should you have information for the period 1945-1979 this would also be useful.

Can you advise me whether or not you have the relevant data, or inform me where I could acquire them. In addition it would be very beneficial for my research if I could be granted an interview with a member of your administration specialising in these issues.

Last but not least I want to stress that all data acquired are going to be used strictly for my research purposes, properly acknowledged and confidentially respected.

I thank you in anticipation of your reply.

Yours sincerely,

K. DIKEOS (MR.)
Dear Mr. Dikey,

We have received your enquiry/order of 17/12/90 requesting information on private health care paid by employers.

Please see paragraph/s 8 below:

1. We have forwarded your letter to

2. The title you mention is not obtainable from this Department but from:

3. The title you require is now out of print.

4. We cannot trace the publication. Do you have any further details?

5. We can only accept cash with order. Please send a sterling cheque payable at a British bank to the value of £ : and made payable to the Department of Trade and Industry.

6. The publications in the attached reading list/listed overleaf may be of use to you. Your public library should either have copies or be able to obtain them for you.

7. The attached leaflet/s should provide the relevant information.


Yours sincerely,

[Signature]

for Librarian, Reader Services
Library & Information Centre
Room LG09

Lib/2
Edinburgh, 17/12/1990

Dear Sirs,

I am a postgraduate student pursuing research on the British health services, and on the private provision of health care in particular. I am very interested in the case of private health care provision for the skilled manual workers (classified by the Central Statistical Office as C2) in automated industries. My main interest is examining the case of workers whose subscription is paid by employers in addition to their monetary wage. The focus of the research is post 1979, but should you have information for the period 1945-1979 this would also be useful.

Can you advise me whether or not you have the relevant data, or inform me where I could acquire them. In addition it would be very beneficial for my research if I could be granted an interview with a member of your administration specialising in these issues.

Last but not least I want to stress that all data acquired are going to be used strictly for my research purposes, properly acknowledged and confidentially respected.

I thank you in anticipation of your reply.

Yours sincerely,

K. DIKEOS (MR.)
KONSTANTINOS DIKEOS
EXT. 6203. (or direct line 650.4236)

To the
Department of
Employment,
Caxton House,
Tothill Street,
London SW 1 H9NF
ENGLAND.

Dear Sirs,

I am writing with reference to my previous letter of December 17th 1990 requesting information for my research project. Since it is possible that my initial letter was lost in the Christmas mail, I am sending a fresh copy of it. As this is now a matter of urgency, I should be grateful to receive a reply from you as soon as possible.

Yours sincerely,

KONSTANTINOS G. DIKEOS.
Dear Mr Dikeos,

Thank you for your letter of 11 February about the provision of private health care.

I have spoken with officials at the Department of Health and they have agreed that the matters raised are there responsibility.

I am therefore forwarding your correspondence to them for direct reply.

Yours sincerely,

RICHARD HOY
Personal Assistant
Dear Mr. Douglas,

I am writing with reference to our telephone conversation earlier today. I am a Ph.D candidate at Edinburgh University, working on issues of absence from the workplace due to health reasons. As a part of my research project, I would like to relate the days of absence due to restricted activity (as appearing in the Social Security Statistics) to the anticipated (or planned) days of work for each year since 1962, for social classifications ‘Intermediate and Junior non manual’, ‘Skilled Manual and Own Account non Professional’, Semi-Skilled Manual and Personal Service’ and ‘Unskilled Manual’.

I wonder whether you could help me even by advising about the raw data of Table 1.12 of the Employment Gazette, especially in the context of my project. The Tables themselves are of little use to me as they exist in the Employment Gazette, since they do not mention the aggregate days worked, and they concentrate only on heavy industry, while the Social Security data give the aggregate absence.

I understand that I might be requesting something that may not exist in such detail, but should you have any relevant data available I would be very happy to work on them.

You can contact me either by post at this address or daily at 650.4236 (office) or 650.8439 (computers’ centre).

I thank you in anticipation of your reply.

Yours sincerely,

KONSTANTINOS G. DIKEOS.
University of Edinburgh  
Department of Politics  
31 Buccleuch Place  
Edinburgh  
EH8 9JT  
24 April 1991

Dear Mr Dikeos,

Thank you for your letter dated 12 April 1991.

Unfortunately, we do not hold data on the anticipated (or planned) days of work by classifications such as "manual" "non manual" etc. The only data we can provide is for hours worked by operatives in manufacturing industries (Employment Gazette, table 1.12).

I have approached other statistics sections within the Department but am still unable to find an answer to your enquiry.

I am sorry I cannot help you any further, but would like to wish you luck with your project.

Yours sincerely,

Peter Douglas.
4 March 1991

Mr K Dileos
Department of Politics
University of Edinburgh
31 Buccleuch Place
Edinburgh EH8 9JT

Dear Mr Dikeos

Your letter to the Department of Employment has been passed to us for reply.

I have to tell you that it is extremely difficult to extract this kind of information. Our organisation was only formed four years ago and so our statistical research is still in its infancy.

You may have better luck if you approached BUPA or PPP, or even the major employers directly.

Yours sincerely

Anthony J Byrne
Chief Executive
Edinburgh, 9/11/90

Dear Sirs,

I am a Ph.D. student at the Edinburgh University, pursuing research into the health services in contemporary Britain, their potential future development and their political repercussions. A significant part of my research is devoted to the analysis of the non public sector provision of health. I am especially interested on issues of:

a) The financial data of the ‘private’ health providers, ie the annual balance sheet, including matters of capital investment and reinvestment;

b) The data about the number of hospitals, beds, doctors, and subscribers; and

c) The occupation of the subscribers, or their classification according to social class (by the Central Statistical Office and the General Household Survey standards) and the form of their subscription (eg through employer, trade union or whatever).

I have already located a considerable amount of data in the various editions of the “Social Trends”, the “General Household Survey”, and the “Social Attitudes Survey”, but I would appreciate it if you supplied me with additional information. If you are unable to send me copies of the relevant documents, I should be grateful if you would let me know where these papers are available. It would also assist my research greatly if I could be granted an
interview with a member of your Association. I would like to stress that these data will be used strictly for my research purposes.
I look forward to hearing from you, and I thank you in anticipation of your reply.

Yours sincerely,

K. DIKEOS (Mr.)
Edinburgh, 7 December 1990

Dear Sirs,

In reference to my letter of 9/11/90, I would like to mention that I have not received any reply from your Association. Considering the possibility of the letter having been lost in mail, I am sending a new copy of it attached to this one.

Yours sincerely,

K. DIKEOS (MR.).
Dear Mr K Dikeos

I am writing in reply to your letter of 9 November 1990 on information for your research.

The best sources of information on the private health sector are:

a) "Laing's Review of Private Health Care" published by Laing & Buisson 111 Regents Park Road London NW1 8UR Tel: 071-722-9272

The next directory is due to be published in January 1991 and will include 1989 data.

b) The Fitzhugh Director of Independent Healthcare Financial Information Acute Sector. Fifth edition 1990-91, Published by Healthcare Information Services 12 Riverview Grove London W4 3QJ Tel: 081-994-8791

This includes statistics on hospital providers and information from their annual reports and accounts.

c) A useful commentary on current issues in the sector is provided in Monopolies and Mergers Commission, BUPA and HCA: a report on the merger situation, published by HMSO March 1990 £8.10 CM 996

Data about the number of independent hospitals and beds can be obtained from the Independent Hospitals Association, Africa House, 64-78 Kingsway, London WC2 B6BD.
As you probably know consultants in the NHS may spend some time working in the private sector as well as fulfilling their NHS contracts. BUPA has identified over 12,000 consultants from our records to whom we make payments for private work undertaken.

The occupation of the subscribers and their classification according to social class is available in the General Household Survey. Further information on BUPA subscribers would be considered confidential information, as would the form of their subscription.

I enclose a factpack of information to help you with your research. After you have studied the above sources, I would be grateful if you could write again giving more detail about the issues that you would like to discuss in an interview.

I am sure you are aware of the commercial sensitivity of information, and although we would not be prepared to discuss or supply confidential information and plans, it may be possible to discuss the general issues.

I think it is important to make these provisos clear at this stage.

Yours sincerely

Kate Roxburgh (Mrs)
Policy Research Manager

enc.

Dear Mrs. Roxburgh,

In reference to our earlier correspondence about my research project, I would like to thank you again for your letter of the 5th of December 1990 (your reference PAC/KR/cm) which I have found particularly useful. As I have collected most of the information available for my research project, I think that at the present stage it would be very beneficial for my Thesis if I could be granted with an interview with a member of your staff. During this interview I would like to discuss the general issues concerning the subscribers of BUPA, the growth of BUPA during the eighties (and the possible impact the NHS reforms had on this growth) and if possible the outline of the plans of your Association for the nineties. You can remain assured that I will not attempt to intrude the privacy of subscribers and I will respect the commercial sensitivity of any information. Last but not least I would like to restate that any information acquired will be treated with confidentiality and used only in close relation to my research project.

Would it be possible for you to arrange an interview for my any time during the University Easter vacation (18 March to 12 April) and let me know about it about one week (or preferably ten days) in advance?

Yours sincerely,

KONSTANTINOS G. DIKEOS (MR.)
PAC/KR/cm
27 March 1991

Mr K G Dikeos
Department of Politics
University of Edinburgh
31 Buccleuch Place
Edinburgh
EH8 9JJ

Dear Mr Dikeous

Thank you for your letter of 13 March. I regret that I do not think it would be advantageous to you to come to BUPA because the subjects that you wish to discuss are commercially sensitive and we would not want to discuss these issues outside the organisation. However, I have put together a dossier of speeches given publicly by the senior management of BUPA in the last two years which should be of help in your analysis.

Yours sincerely

Kate Roxburgh (Mrs)
POLICY RESEARCH MANAGER
Dear Sirs,

I am a Ph.D. student at the Edinburgh University, pursuing research into the health services in contemporary Britain, their potential future development and their political repercussions. A significant part of my research is devoted to the analysis of the non public sector provision of health. I am especially interested on issues of:

a) The financial data of the 'private' health providers, ie the annual balance sheet, including matters of capital investment and reinvestment;

b) The data about the number of hospitals, beds, doctors, and subscribers; and

c) The occupation of the subscribers, or their classification according to social class (by the Central Statistical Office and the General Household Survey standards) and the form of their subscription (eg through employer, trade union or whatever).

I have already located a considerable amount of data in the various editions of the “Social Trends”, the “General Household Survey”, and the “Social Attitudes Survey”, but I would appreciate it if you supplied me with additional information. If you are unable to send me copies of the relevant documents, I should be grateful if you would let me know where these papers are available. It would also assist my research greatly if I could be granted an interview with a member of your Association. I would like to stress that these data will be used strictly for my research purposes.

I look forward to hearing from you, and I thank you in anticipation of your reply.

Yours sincerely,

K. DIKEOS (Mr.)
26th November 1990

Mr. K. Dikeos
University of Edinburgh
Department of Politics
31 Buccleuch Place
Edinburgh
EH8 9JT

Dear Mr. Dikeos,

Thank you for your letter dated 13th November 1990 regarding your research into the health services in Britain. I have enclosed a copy of our 1989 Report and Accounts and a brochure on Principal Investment Management Services which I hope will be of use to you.

There are also two publications which may be useful for you if you are not already aware of them. The first is "The Fitzhugh Director of Independent Healthcare Financial Information Acute Sector." This is published by Health Care Information Services, a division of WAF Health Care Consultant Ltd, 12 Riverview Grove London W4 3QD. Tel: 081 994 8791 Fax 081 742 2418. The second is the "Laing's Review of Private Healthcare" published by Laing & Buisson Publications Ltd, 1 Perren Street, London NW5 3ED. Tel: 071-671 7306.

I hope this information is of use to you.

Yours sincerely,

Debby Cahalane
Administrator, Strategic Communications
Dear Ms. Cahalane,

Thank you for your letter and information package of November 26th, (your reference: A/wp/dc2) which I have found very useful. There is some additional information I would like to request though.

a) Since I am particularly interested in the expansion of the Private Health Care Option in Britain I would like to have information on the “Investment Income” and the “Excess of Income over Expenditure” (appearing in page 24 of your “Report and Accounts”) and on “Subscriber Population”, “Number of People Covered” and “Subscriptions and Invested Income” (appearing in page 30 of your “Report and Accounts”), for all years since 1948. It would be very helpful if I could have photocopies of the relevant pages of your previous Reports and Accounts.

b) I would also like to have information on the number of people per type of subscription, viz. whether they are insured through an employer or private scheme, and on the social class of your subscribers. My particular interest is about social class C2 (skilled manual workers), especially in relation to their type of subscription (private or employer provided). Last but not least, I wonder if it might be possible to arrange an interview with a member of your Association, since some of the information I ask for might not appear in paper.

I thank you in anticipation of your reply.

Yours sincerely,

K. DIKEOS (MR.)

Dear Ms. Cahalane,

I am writing in reference to our earlier correspondence (your reference A/wp/dc2) about my research project. Since I have collected most of the empirical data I need for my Thesis I wonder whether it would be possible for me to be granted with an interview with a member of your staff to discuss issues related to my project. You can be assured that any information acquired at this interview will be treated with confidentiality and used only for my research purposes.

Would it be possible for you to arrange an interview for me during the University Easter vacation (18 March to 12 April) and let me know about it about ten days in advance? I thank you in anticipation of your reply.

Yours sincerely,

K. DIKEOS (MR.)
Dear Sirs,

I am a Ph.D. student at the Edinburgh University, pursuing research into the health services in contemporary Britain, their potential future development and their political repercussions. A significant part of my research is devoted to the analysis of the non public sector provision of health. I am especially interested in issues of:

a) The financial data of the ‘private’ health providers, i.e., the annual balance sheet, including matters of capital investment and reinvestment;

b) The data about the number of hospitals, beds, doctors, and subscribers; and

c) The occupation of the subscribers, or their classification according to social class (by the Central Statistical Office and the General Household Survey standards) and the form of their subscription (e.g., through employer, trade union or whatever).

I have already located a considerable amount of data in the various editions of the “Social Trends”, the “General Household Survey”, and the “Social Attitudes Survey”, but I would appreciate it if you supplied me with additional information. If you are unable to send me copies of the relevant documents, I should be grateful if you would let me know where these papers are available. It would also assist my research greatly if I could be granted an interview with a member of your Association. I would like to stress that these data will be used strictly for my research purposes.

I look forward to hearing from you, and I thank you in anticipation of your reply.

Yours sincerely,

K. DIKEOS (Mr.)
21 November 1990

Mr K Dikeos
University of Edinburgh
Department of Politics
31 Buccleuch Place
Edinburgh
EH8 9JT

Dear Mr Dikeos

Thank you for your letter of 13 November and I note that you are doing research into health services. For your information I have pleasure in enclosing details of WPA's private health insurance schemes which are currently offered to individual and corporate group subscribers. I am also enclosing a copy of our Report and Accounts for 1989 and I hope that this will give you the information you require.

Today WPA covers over half a million people in the UK and the total number of people covered by health insurance schemes is approximately six million representing ten percent of the population.

I regret that we do not at the present time have a branch office in Scotland and therefore it may be difficult for you to have an interview with a member of our staff. However if you would like me to give you any further information regarding our service, please let me know.

I hope the enclosed will be of interest to you.

Yours sincerely

DAVID ASHDOWN
Marketing Director

Encs
Mr. David Ashdown,  
c/o Western Provident Association,  
Rivergate House,  
70 Redcliff Street,  
Bristol,  
BS1 6LS  

Edinburgh, 28 November 1990.

Dear Mr. Ashdown,

Thank you for your kind reply of November the 21st. Since my research project relates to the period since 1948, there is some additional information I would like to request for.  

a) Copies of “Income and Expenditure Account” (as appearing in page 5 of your current “Report and Accounts”) and of data about “Net Funds Available for Investment” (as appearing in page 7) for all years since 1948.  
b) Number of your subscribers and type of subscription (privately or through company scheme) since 1948.  
c) Social classification of your subscribers, and type of subscription, especially for the social class C2 (specialised manual workers) since 1948 with particular interest in the period after 1980.  

If it is difficult to send these data by post, or if you think that they will be acquired more easily if I visit your Offices and have an interview with a member of your Association, please let me know, as I am willing to come to Bristol for such a reason.  

I thank you in anticipation of your reply.

Yours sincerely,

K. DIKEOS.
Dear Mr Dikeos,

Thank you for your letter of 28 November and I appreciate that your research project is relating to the period since 1948, I regret however that I am unable to let you have the detailed information you require about WPA membership income expenditure and social economic groups from 1948.

I am sorry my reply cannot be more favourable.

Yours sincerely

DAVID ASHDOWN
Marketing Director

Dear Mr. Ashdown,

I am writing in reference to our earlier correspondence (your references DGA/CTJ 21 NOVEMBER AND 10 DECEMBER respectively) about my research project. Since I have collected most of the empirical data I need for my Thesis I wonder whether it would be possible for me to be granted with an interview with a member of your staff to discuss issues related to my project. You can be assured that any information acquired at this interview will be treated with confidentiality and used only for my research purposes.

Would it be possible for you to arrange an interview for me during the University Easter vacation (18 March to 12 April) and let me know about it about ten days in advance? I thank you in anticipation of your reply.

Yours sincerely,

K. DIKEOS (MR.)
Dear Mr Dikeos

Thank you for your letter of 13 March and I am sorry for the delay in reply, but this has just come to attention as I have been on leave for two weeks and have just returned to the office.

I appreciate that you would like to meet with one of our staff to discuss your project. You may be interested to know that we have recently appointed a representative in Scotland who is:

Stephanie Dunbar
Tel No 0383-882147

If you would like to discuss WPA then you may like to contact her and arrange a meeting. I hope this will be of help to you.

Yours sincerely

DAVID ASHDOWN
Marketing Director
The interview had five areas of interest.
1) The market.
2) Functional and Financial Matters of WPA.
3) Personnel and Equipment Matters.
4) Subscribers, Subscriptions.
5) NHS and Provident Associations. The relation.

1) The Market.
a) Competition with the giants. WPA is relatively smaller than both BUPA and PPP. How do you compete with them? Is it on ‘price’ matters, geographical area, specific services or what? Do you target specific part of the market only? (eg bank employees and white collars)
*Compete through price. This does not necessarily mean cheaper. WPA provides the cheapest insurance for the (best) benefit provided.*
b) Why Scotland? Is it part of a general strategy?
xxxxx (unclear recording on tape)
c) Commercial insurers are expanding their targets at health. Are they rivals or do you cooperate with them? What is the significance of this for health care market and health policy in general? Especially due to the strong anti-private health ideology in parts of the population, and the recent ‘allegations’ against the government?
*Some are direct competitors. The very small ones do not seem a problem, but WPA ‘meets’ the larger companies often.*

2) Functional and Financial.
A) Function of the WPA
a) Is the WPA in real terms in the Indemnity Insurance Business? (this commend appears in Public/Private Mix in health care). Brief question on own hospitals etc. (we will come to this later).
*WPA pays the provider of health care. Similar to motor insurance, who pays the garage.*
b) Do you give money/cash to the holder/subscriber, or do you pay the provider directly? The issue of ‘choice’. Who chooses the doctor/hospital etc.?
The idea of vouchers/choice is similar to a -State run- system to replace the NHS (early eighties).
The patient/subscriber has to visit his/her GP. Then the option is given by WPA according to the GP's advice. The GP is usually aware of the subscription (since his/her patient mentions it)

c) What about the other two leading providers (BUPA, PPP)

*Ms. Dunbar would not like to commend on other companies.*

B) Finance.
a) ‘Net Funds Available for Investment’. Data not available since 1948. Are there any other data available?

*Ms. Dunbar suggested that I asked their head office.*
b) Are all these funds (re) invested?

*Ask head office.*
c) What is this reinvestment on? i) new equipment? ii) New hospitals? iii) other/what?

*Question does not stand as WPA does not have hospitals.*

3) Personnel and Equipment.
a) i) The form of the consultant contract for NHS ii) for WPA

*WPA does not have any contract with consultants or direct links with them.*
b) Full time doctors WPA. i) consultants, ii) senior registrars, iii) registrars, iv) junior change over the years?

*See previous question. WPA employs some doctors but on an ‘advisory’ not ‘curing’ role.*
c) Full time equivalent nurses WPA. Change over the years?

*No nurses either.*
d) Fees charged by consultants and hospitals. Are they ‘unified’ or do they vary? If they do which is the variable? ? Is there any regulation?

*Regulation of prices is through the BMA guidelines. WPA follows these guidelines.*
e) Hospitals (WPA) i) own, ii) coownership?

*WPA do not poses any hospitals. It is against the policy of WPA to poses hospitals.*
f) beds

*Question does not stand!*
g) Medical centres, ‘quick repair’, monitoring, especially for large groups of people.

*No, not medical centres, or ‘quick repair’ or monitoring centres either.*

h) Equipment (surgical and ‘quick repair’ monitoring).

*No.*

4) Subscribers.
a) Is individual/family subscription higher than corporate subscription?

*No, it is the corporate subscription which is (slightly) higher.*
b) Compare the rates of change of the two forms of subscription especially since 1980. Ms. Dunbar did not have any detailed information; she suggested to ask head office.

c) Are skilled manual workers (especially of the younger ages) insured through their employer? as a part of the wage package? I would particularly like to focus on the Skilled manual workers (C2 by Central Statistical Office, classification of occupation).

There is an increase, but its size is not known. There is not any specific evidence for a change. However, some time ago companies used to insure their directors while now they insure other employees as well. Junior managers etc. Some skilled manual workers are included, but the size is not known.

d) Is it part of your job and of the company policy to approach employers and do you have certain targets (especially in relation to the previous question)? Do employers approach you by themselves for these ‘special’ employees of for their ‘special’ employees in general?

(If these numbers are confidential is it possible to have indication about tendencies? Especially after 1980?)

No, these negotiations are done mainly through insurance brokers. They are responsible for this. Ms. Dunbar coordinates the brokers and the brokers/head office relation.

e) Other ‘workers’ i) White collar a) High skills b) low skills. ii) blue collar a) skilled b) semi skilled g) unskilled. How many, under what form? (employer or self insured)

See earlier questions.

f) Are there any such contracts (for ‘corporate bodies/groups of people) arranged through the Trade Unions? Which Unions? For which ‘category’ of workers or employees in general?

Mainly through voluntary schemes. Some sports teams etc. Unions are included. Maybe not the large/overall unions but union branches.

g) Do you know how these contracts were negotiated? (especially these of questions c and d)

Negotiation between, Employer-Employees and Employer-WPA.

5) National Health Service and Western Provident Association.

a) Pay beds have they helped WPA and other associations?

Yes, but it depends on the area and the existence of private hospitals as well. Additionally the excess is unknown.


Though the time allowed is limited, the post 1980 consultant contract has helped WPA.

c) Conditions of the NHS (waiting lists, strikes etc.) do they influence the market?

Yes; Short waiting lists in some areas make opting private not a ‘necessity’ but a ‘luxury choice’.

d) In February 1982 D. Damerell (BUPA) mentioned the need of more state assistance for the provident associations (tax relief for all subscribes). Do you believe that you need more
state assistance in such a form?
Yes, something like this would be helpful.
e) The recent changes in the NHS; internal market and choice. The relation with Provident Associations. How are you going to exploit the internal market?
It is going to bring more competition, but we have to wait and see.

6) General.
a) All issues raised so far were in relation to the WPA. Do you have any information, or indication about these issues as far as BUPA and PPP are concerned?
Ms. Dunbar re-mentioned that she would not like to commend on the other companies. She only mentioned that this is a period of expansion for private health care.

We would like to thank Ms. Stephanie Dunbar for granting us with this interview and for the information given.
Dear Ms. Dunbar,

Thank you for the interview of the 15th which I have found most helpful for my research project. I am sending you a copy of the notes I kept after listening to my tape. These notes do not perform a word by word transcription of our discussion, but are -I think- a fair presentation of it. Do let me know if you would like a copy of the tape containing this interview. I apologise for the delay of this letter caused by a small technical problem. I hope everything goes well with your fingers.

Kind regards,

KONSTANTINOS G. DIKEOS.
Dear Sirs,

I am a postgraduate student pursuing research on the British health services, and on the private provision of health care in particular. I am very interested in the case of private health care provision for the skilled manual workers (classified by the Central Statistical Office as C2) in automated industries. My main interest is examining the case of workers whose subscription is paid by employers in addition to their monetary wage. The focus of the research is post 1979, but should you have information for the period 1945-1979 this would also be useful.

Can you advise me whether or not you have the relevant data, or inform me where I could acquire them. In addition it would be very beneficial for my research if I could be granted an interview with a member of your executive committee specialising in these issues. Last but not least I want to stress that all data acquired are going to be used strictly for my research purposes, properly acknowledged and confidentially respected.

I thank you in anticipation of your reply.

Yours sincerely,

K. DIKEOS (MR.)
Mr K Dikeos  
University of Edinburgh  
Department of Politics  
31 Buccleuch Place  
Edinburgh EH8 9JT

Dear Mr Dikeos

PRIVATE HEALTH CARE

Thank you for your recent letter concerning private health care in the UK.

The TUC's policy that health care should be provided by the National Health Service and should be free at the point of use. The General Council of the TUC believe that this is the most efficient way of providing health care to the whole community and is the best way of reducing health inequalities. The TUC has campaigned over the years in support of the NHS and opposes private health care.

I hope this clarifies TUC policy on private health care.

Yours sincerely

Joanne Segars  
Assistant Secretary  
Social Insurance and Industrial Welfare Department

General Secretary: Norman Willis  
Deputy General Secretary: John Monks  
Assistant General Secretaries:  
Roy Jackson and David Lea, OBE
To Ms Joanne Segars,
Assistant Secretary,
Social Insurance and Industrial
Welfare Department,
c/o the Trade Union’s Congress,
Congress House,
23-28 Great Russell Str.
WC 1B 3LS
LONDON
ENGLAND.

Edinburgh, 11/2/1991

Dear Ms Segars,

(Your reference: SIIW/JS/JP.)

Thank you for your letter of January 17th clarifying the TUC’s policy over health care in Britain, and I take the point that the TUC is consistent in its policy of opposition to the privatisation of health care provision. It seems to me though that there has been a small misunderstanding of my letter of December 17th. Apart of the TUC policy, I am very interested to know whether there are any data concerning the private health care provision to skilled manual workers (classified as C2 by the Central Statistical Office), especially in the modern automated industries. My main interest is examining the case of C2 workers whose subscriptions are paid by their employers in addition to their monetary wages. I should be most grateful, if you would let me have such data, or if you could advise me where I could acquire them. In addition it would be very beneficial for my thesis if I could be granted an interview with you or a member of your executive specialising on these issues. I thank you in anticipation of your reply.

Yours sincerely,

KONSTANTINOS G. DIKEOS.
To the
Confederation of
British Industries,
103 New Oxford Street,
London WC 1A 1DU.

Edinburgh, 17/12/1990

Dear Sirs,

I am a postgraduate student pursuing research on the British health services, and on the private provision of health care in particular. I am very interested in the case of private health care provision for the skilled manual workers (classified by the Central Statistical Office as C2) in automated industries. My main interest is examining the case of workers whose subscription is paid by employers in addition to their monetary wage. The focus of the research is post 1979, but should you have information for the period 1945-1979 this would also be useful.

Can you advise me whether or not you have the relevant data, or inform me where I could acquire them. In addition it would be very beneficial for my research if I could be granted an interview with a member of your executive committee specialising in these issues.

Last but not least I want to stress that all data acquired are going to be used strictly for my research purposes, properly acknowledged and confidentially respected.

I thank you in anticipation of your reply.

Yours sincerely,

K. DIKEOS (MR.)
To the
Confederation of
British Industries,
103 New Oxford Street,
London WC 1A 1DU.

Edinburgh, 19/2/92

Dear Sirs,

I am writing with reference to my previous letter of December 17th 1990 requesting information for my research project. Since it is possible that my initial letter was lost in the Christmas mail, I am sending a fresh copy of it. As this is now a matter of urgency, I should be grateful to receive a reply from you as soon as possible.

Yours sincerely,

KONSTANTINOS G. DIKEOS.
Ref NC/VKH/453

18 February 1991

Mr K Dikeos
University of Edinburgh
Department of Politics
31 Buccleuch Place
Edinburgh
EH8 9JT

Dear Mr Dikeos

Thank you for your letter. I have carefully considered the information and material we have on medical care. Unfortunately, none of it is of any relevance to your research.

I have enclosed a copy of a CBI publication "Managing for attendance". It may be of some relevance to your work.

I wish you well with your research.

Yours sincerely

Natalie J Coney
Adviser
Environment, Health and Safety Group
Edinburgh, 28 November 1990,

Dear Mr. Grimes,
I am a Ph. D. student in the Department of Politics at Edinburgh University pursuing research on the British health service, and on the National Health Service and the government spending allocated to it in particular. In today’s ‘Independent’ you are quoted (Jack O’ Sullivan “Extra funding for improvements to NHS ‘wiped out’”) claiming that “From the money available from the central government there have been no funds available for development of the service. In fact there is a small deficit.” Later on the article mentions your ‘Health Database 1990’, as a source of information on NHS expenditure.
As the whole issue is closely related to my research project, I would like to have more information on your ‘Health Database 1990’ and to know whether there is a general ‘Health Database’ for the post war period in CIPFA.
Is there any way I could obtain copies or printouts of your database, or I could be granted permission to visit your premises and use the database there.
Last but not least, I wonder whether it could be possible to come and talk to you about your work. This would be of very great help to me in my research.
I thank you in anticipation of your reply.

Yours sincerely,

K. DIKEOS (Mr.)
Dear Mr. Dikeos,

Thank you for your letter of 28 November concerning information on our 1990 Health Database for your research project.

This may be obtained by using the enclosed order form - due to the cost involved you may wish to get your library to purchase a copy. It is possible for you to use our library facilities here at CIPFA but we require twenty four hours notice. Please consult our librarian, Mr. Bali Sansoa, extension 314, regarding library appointments.

Finally, concerning your enquiry about a post war health database; unfortunately our health database has only been in existence for the past five years. Please contact Jonathan Wise, (extension 290), or myself for any further details that you may require.

Yours sincerely,

Miss Anita Denham
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