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Which future for the UK National Health Service (NHS)?

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The National Health Service (NHS) became quickly the nation's most loved and most respected institution. There have been many open attacks on the NHS after it was established in 1948, but all have failed. The "reform" programme of today could succeed only if it was presented not as an alternative to the NHS, but as vital to its rescue, after many years of under-funding. The NHS is now close to death.

In spite of everything, medical science and professional thought will continue to advance, continually adding to our long-term advantage as advocates of open and evidence-based rather than covert and populist policies. Of course, we may fail. Even then, there will still be the more civilised countries of Scandinavia to fight for a more human world. One way or another, we shall win.

I was born in 1927, and qualified in medicine in 1952. I was reared in an intellectual culture based on ideas developed in the two decades preceding World War 1. This assumed that modern history was a social progress, wherein social, cultural and material inequalities would diminish, and democratic society would advance from passive consent toward active participation. This culture had powerful enemies, but we knew who and where they were. From the mid-1930s onwards, we learned how to fight them. After 1945, with fascism out of our way, most arguments between intellectuals within this culture concerned not where we wanted to go or who were our friends, but how fast we could get there. The institutional vehicle for this progress was the social-democratic welfare state. Its apex was the NHS.

In the UK, this era closed in 1979, with election of Margaret Thatcher. She had a simple but perceptive mind. Sooner than her colleagues, she recognised that for the owners and controllers of the UK economy, and for

the state acting on their behalf, most of the welfare institutions created before World War 1, and greatly enlarged after World War 2, had become optional. Collapse of the Soviet experiment in command socialism, China's transition to command capitalism, and abdication of responsibility by our own Democratic Socialists as soon as ideological competition with communism came to an end, had eliminated the threats which begat the welfare state in the first place. Simply to defend capitalist laws and institutions against Bolshevism, state welfare institutions were no longer necessary. Educational, medical and social services needed for any complex industrialised society could be run as well, probably more efficiently, and certainly more profitably, by commercial providers rather than the state. Consumer choice in competitive markets might be more popular than bureaucratic accountability to citizens in state monopolies. How consumers chose to spend their money was probably a more effective and comprehensible form of accountability than voting for politicians, so democracy could be redefined as an economic rather than political process. Capitalism equated with democracy, and socialism equated at best with authoritarian government, at worst with dictatorship. We have to admit that experience in the USSR, China, Vietnam, Cuba and West Bengal all gives some support to that argument.

This set of views, and the post-modernist philosophy and consumerist culture derived from it, swept all before it among the most powerful and influential sections of the UK intelligentsia, including most of those who began as Marxists. After she was deposed in favour of a less socially divisive and more electable leader, Thatcher was asked what she believed was her greatest achievement. Her answer was "New Labour". In less openly aggressive forms, the advocates of Tony Blair's New Labour accepted all her social and economic policies in principle. By the UK parliamentary Labour Party and the shadow cabinet, they have still not been repudiated. All national UK political parties now share a new consensus, first defined by Thatcher in the 1970s, within which disagreements concern not direction, but how far and how fast the UK can be returned to 19th century conceptions of society, decorated, disguised and fortified by 21st century technology. And not only politicians: several generations of high-flying economic, administrative, scientific and medical graduates have grown up ignorant of any other philosophy.

However, this powerful and still dominant Neo-Liberal view is weakened by three gigantic flaws. They will ultimately prove fatal.

Three fatal flaws

The first flaw is that though these views have been either embraced, or at least regretfully accepted as inevitable, by all leading politicians and a large majority of media commentators, they have never been opened to honest public debate in the seven areas of greatest potential contention: health care, social care, education, housing, transport, control of industry and finance, and distribution of wealth. Providing they can find a publisher or gain access to broadcast media, anyone can say what they like about any of these, but no significant national political party presents any fundamentally different policies for any of them, comparable to their differences before 1945, and consolidation of the welfare state. Thatcher's rule was never supported by more than about one-third of voters. Dominance of her simplistic ideas always depended more on the weakness of her Liberal, Labour and Social-Democrat opponents, than on truly popular support. The Neo-Liberal programme has never been put to a clear popular vote for any of the social institutions to which it is being applied. People who still retain intuitive belief in socially inclusive neighbourhood schools and free university education, and in free, regionally or nationally planned health care, in generous social care, in social housing for need rather than profit, in nationalised railways, in democratised industry, in regulated financial services and in progressive taxation, now have no major party to vote for. The Labour Party, which once proclaimed all these policies as its aims, has opposed them in practice ever since it won power in 1997 with its largest-ever majority. In the greatest economic and social crisis of capitalism since 1929, all it can offer is a slower and more cautious retreat to *laissez-faire* economy than is promised by the Conservative Party. Numerous public opinion polls over the past three decades have confirmed either large majorities, or at least minorities larger than the one-third who voted for Thatcher, opposed to all these Neo-Liberal "reforms". There is a potentially powerful alliance of middle-class and working class voters available to support any credible politician with enough courage and imagination to lead them. The global crisis of capitalism initiated by the bank failures of 2007, still accelerating today, will promote growth of this unrepresented dissenting majority, though a widespread decline in political literacy means that at least some of this dissent may well slide terrifyingly towards various forms of neo-fascism.

The second flaw is less obvious, but more important. The entire Neo-Liberal programme rests on an assumption that all production of wealth will function most efficiently, with greatest productivity, through industrialised (and, so far as possible, mechanised) labour. This will have a commodity product, promoted and sold to consumers by providers motivated

by profit and competing for highest apparent quality at lowest apparent price. For simple commodities like automobiles or baked beans, experience has shown this assumption is correct, but these are no longer major growth industries, either for employment, or for generation of wealth. Commodity manufacture is stagnant. Deregulated growth of financial services, the alternative industry most valued by leading UK politicians but most despised by the public, is what got us into this crisis. Only conformist politicians or economists could believe that this industry could get us out of it, even supposing that foreign investors are likely ever again to trust its judgement.

So where is economic growth, in employment or production of wealth, to come from? The two obvious candidates are education and health care. They are both increasingly labour intensive. The quality of their product, and their staff morale and motivation, both depend mainly on staff having enough time to use their skills as they have been taught. They both produce the products most valued by most of the public, healthier and more educated people.

Thatcherised politicians and economists are unable to recognise this. For them, these two industries are not wealth-producers, but wealth-consumers. They produce not more profitable commodities, but higher taxes. So for them, progress and "reform" mean remodelling of both educational and health care systems on industrial lines, as if education and health care were commodities, transferred from competing corporate providers to consumers exerting market choice. From this, they believe higher productivity is bound to result. Whole lives devoted to teaching or health care, serving communities long enough to learn from seeing the results of their work, will be things of a past which never, for most people, resembled the sentimental picture of kindly young teachers or devoted old GPs. Instead, hitherto self-serving professionals will enter the same states of permanent insecurity as all other workers in a fully industrialised society. Their jobs will survive only if they contribute to victory of their own employing authority over its competitors, in a race to reduce labour costs; so say the NeoLiberals. They will not be believed.

Thirdly and finally, Neo-Liberal economics and post-modern philosophy increasingly violate the rules of scientific thinking and evidence-based decision, setting them on a collision course against our finest exponents of innovative science. In science, the validity of any theory depends on its explanatory and predictive power, tested against representative data from the real world. Neo-Liberal economics has spectacularly failed to pass either test. Post-modern philosophy simply evades testing, by denying even the

possibility of useful analysis of evolving society. This alienates a growing and increasingly powerful class of highly skilled professionals, essential to continued development of capitalism in the new age of intellectual property.

This entire sequence of reasoning is fallacious. It hopelessly misunderstands the nature of wealth production in these two essentially similar forms, education and health care. Neither pupils, students nor patients are ever consumers, except in particular, transient and isolated circumstances (1). The success of both education and health care depend on their active co-operation with professionals: not simply on doing what they are told, but on understanding and interpreting what they are told, and linking it with their own personal experience. In this way a wealth product (but not a commodity) is created, valuable both to the individual and to society. Successful outcomes of both educational and medical processes depend on agreement between students/ patients on one hand, and staff professionals on the other, about the nature of the problems they address, and the relevance and feasibility of their solution. Definition of problems, and relevance and application of solutions, both depend on evidence, commitment and hard work from both sides. Simple division between providers and consumers is a trading concept irrelevant to all but a few crisis situations in medical care. Increasingly, productivity (of outcome, not process) in both education and health care depend on long-term, sustained personal relationships, so that both staff and students/patients can learn from experience of the consequences of their decisions. Preconditions for this, stability, continuity, and personal commitment, are all most easily created and sustained in a public service gift economy aiming to meet needs rather than make profit (2).

The Neo-Liberal programmes for "reform" of education and health care industrialise professional decisions, dividing educational and clinical processes into rational sequential tasks, which can then be delegated to a wider ranged of more specialised but often more narrowly trained (and cheaper) performers. The result has been loss of continuity and imagination, an unstoppable rise in fragmented box-ticking (deplored by thoughtful professionals and hated by the public) and all the disjointed thinking that results from separating staff from the consequences of their decisions.

For example, we know from good evidence that about 85% of the evidence used to reach a medical diagnosis derives from what patients tell us. Only 7% comes from physical examination, and another 7% from diagnostic investigations (3, 4). Ignoring such evidence, with rapid growth in new diagnostic technologies there was recently a suggestion that it is more efficient and cost-effective to employ a technician to undertake a battery of investigations rather than have an expensive clinician spending time listen-

ing to patients (5). In the present state of credulity for every whim from business management, even that could happen.

These "reform" programmes will fail on all measures of outcome, without which any improvements in process are meaningless. In terms of health outcome, they will reduce productivity and efficiency from levels already attained, even within the very imperfect gift economies intuitively developed in UK schools, universities, health centres and hospitals. When the nature of public service gift economy is fully understood and embraced, both by UK professionals and the public, gains in productivity will be possible on a scale not seen since the first industrial revolution.

The Neo-Liberal offensive rides on despair

Outlines of this divergence in public service, between regressive industrialisation and progress towards co-operative gift economy, were emerging in the early 1980s (6). By the early 1990s they were obvious (7). Today, more than 30 years later, commercialisation and industrialisation of the NHS is recognised and detested by a large majority of both staff and public. Yet however regretfully, most accept this process as inevitable, a price that has to be paid for efficient and effective application of technical progress. This is precisely what the most intelligent advocates of "reform" intended and hoped for: not a frontal attack on an immensely popular and comparatively cost-effective public service, but stepwise attrition, using every element of mean-spirited vulgar mythology ("The trouble with the NHS is abuse by patients with trivial, imaginary or self-inflicted problems, which would all go away if they had to pay for it") (8).

There have been many open attacks on the NHS as a gift economy since 1948, but all have failed. The NHS was much more than popular, it quickly became the nation's most loved and most respected institution. The "reform" programme could succeed only if it was presented not as an alternative to the NHS, but as vital to its rescue, after 26 years of under-funding. According to the Wanless report, £267bn less was invested in the UK NHS than the EU average over the years 1972-1998 (9).

And so it is, that after more than 30 years of treatment with increasing doses of this "reform", the patient is close to death. We do, at last, have a well organised movement of doctors and academics in KONP (Keep Our NHS Public), thanks to whom leaders of the British Medical Association (BMA) have been compelled to oppose the latest government proposals for "reform", a hastily prepared jumble of new laws, requiring more pages than the original NHS Act of 1946, which few if any members of parliament had read when they voted for it in September 2011. No effective action has yet

been taken by NHS trade unions, though this is one of the few fields in which their membership is still strong. The "reformers" still hold the initiative. Leaders of the Labour Party dispute the extent and pace of commercialising and industrialising "reforms", but not their nature or direction of travel. As for the public, it is bewildered and in despair. The NHS seems to have only one future, the same as us all: finally to succumb to the market, wringing our hands, but seeing no way to use them to make anything better.

An alternative vision

Apart from predictable support from virtually all news media and capitulation from politicians, the greatest asset for commercialising "reformers" has been pessimism and despair among the public, and passivity from most NHS staff. Nobody working in the NHS ever thought that it delivered the full potential of contemporary medical knowledge to all who needed it, only that it had opened up new opportunities to come closer to doing so. The whole world has a living example of what an already commercialised, and fast becoming industrialised care system does to people, and fails to do for people, in USA, the richest country in the world, USA. We knew the old NHS helped to lead us away from that, and nobody with real experience of the NHS either as staff or patients, ever believed in a golden age. We were just beginning to learn what might be possible through continuing on that new path entirely (as Nye Bevan once called it). The gift economy NHS was a direction of travel, not a destination, but this was enough to sustain high morale at the leading edge of innovation, both for primary generalists and for hospital specialists.

In the first 15 years or so of its existence, the centrally planned NHS achieved roughly equal distribution of medical and nursing staff throughout the UK, a feat the US care system has never even attempted. This was an important step towards social equality, but not nearly enough. Needs for medical and nursing care are not distributed equally.

We have a correlation between numbers of caring professionals and numbers of people, but virtually no correlation between the numbers of caring professionals and numbers of sick people. If professional carers try to meet all needs throughout the populations they serve, they get much higher caseloads and almost impossible workloads, wherever rates of limiting chronic illness are high. According to the vulgar mythology beloved of "reformers", much of this limiting chronic illness is not real, but a proxy for claimed benefits. Morbidity so measured is closely related to age-standardised mortality (r=0.84) (10). Death is never imaginary, and people who feel unwell usually are unwell indeed.

The Inverse Care Law still thrives, 40 years after it was described (11). And naturally so. It is not a law of nature, but a law of the market. The further health care gets from the market, the less this law applies, but for most of those 40 years, all political parties have been trying to drag the NHS back to the marketplace. The "reformers" have an answer to this too. The Inverse Care Law (which, while wringing their hands, they frequently deplore in rhetoric) concerns human behaviour. The marketplace, they say, represents the highest form of human behaviour possible for the general run of consumers, in the ordinary course of their lives. While we all admire and celebrate the human spirit, for most days of the week we are steeped in original sin, each seeking his own advantage. So though it may be deplorable, the tendency of doctors to work where people are rich and healthy, and to avoid work where they are poorer and sicker, is inevitable, a manifestation of unchangeable human nature.

As the authors of their very significant work, Mary Shaw and Danny Dorling, say: "…comparing provision of informal unpaid care over 50 hours a week with population indicators of general health and limiting long-standing illness… *Where no market forces apply, where people give up their time for free to provide care* [for people they know], *an almost perfectly positive care law is found to apply.*" (my emphasis)

Of course it is not quite true that "no market forces apply" to families faced with responsibility to provide more than 50 hours of unpaid care each week for a sick person, and also to stay alive themselves. But to the extent that a family can preserve human rather than market relationships, people seem to behave both humanely and rationally, giving care where it is needed rather than selling it where it is profitable. On this evidence, human nature seems pretty good.

Unfortunately it is not true that human nature is unchangeable. If it were, the advertising and promotion industries would be wasting their time. Responsible citizens can eventually be changed into thoughtless consumers, if enough work is put into degrading them downwards, and none is put into helping them to understand the world they live in, and how to change it. To sustain caring human relationships in capitalist society, where almost any action can be justified as long as it makes money, people must at least have a vision of some better way to live. The NHS gave, and could give again, not just a vision of a more human society, but opportunities to learn in practice how to extend the best present family behaviour throughout a society we can all really believe in. Most of all, this applies to doctors and nurses, who can readily understand that their work should be distributed according to the needs of the communities they serve, as informal carers already do.

How could the Inverse Care Law of professional care bring itself into line with the Positive Care Law of functional families? This should be the real stuff of UK politics. If it were, we would not have to wring our hands and deplore the apathy, indifference and cynicism of voters. For a start, we might remember that the origins of all health care lie not with professionals or the state, but in the care of people for one another, in families, in neighbourhoods, and in shared labour.

Deep and shallow ends

The behaviour and career choices of doctors depend mainly (not entirely) on how they are paid and organised. Though the number of NHS GPs has been increasing, apart from a brief improvement in 1990/91, they have settled disproportionately in areas of lower mortality, lower morbidity, and lower workload, a trend accelerated by concentration of training practices in already well-doctored areas (12). Graham Watt, who first devised this effective metaphor, called it the Drowning Pool.

The depth of this pool is proportional to age-standardised mortality rates, ranked by social class. At the deep end, GPs serving social class 5, the poorest people with highest rates of unemployment and limiting long-term illness, need to deal with about two and a half times more ill health than the most affluent people in social class 1, at the shallow end (13, 14). Their workload is consequently much higher. They exhaust themselves trying to keep afloat, and their patients drown.

As there are only 24 hours in a day, they must work much harder, and have less time to give to each patient. Face-to-face time is the main determinant of quality in primary care, and therefore of appropriate referral to specialist care (15). Time is the currency of primary care (16). We have never had enough of it, and this is the main reason that for most chronic health problems, roughly half have never been recognised by a doctor (even in an NHS where virtually everyone has access to a personal doctor), half of those recognised are not being treated, and half those treated are not well controlled (the Rule of Halves) (17).

Our team in Glyncorrwg reorganised and resourced our work to add systematic proactive anticipatory care in an attempt to delete the Inverse Care Law in a deprived population, essentially by applying what was already known fully to our entire community (how we got those extra resources is an interesting story, too long to tell). After 20 years of that policy, we compared age-standardised mortality over 5 years in Glyncorrwg with that in a socially similar village about 10 km away in the same valley, with good traditional reactive care. Mortality was 28% less in Glyncorrwg for deaths

under 65, and 30% less for deaths at all ages (18). If what we already know were fully applied, there could be a huge rise in productivity, measured by outcome.

Redistribution of resources, wealth, and power

Full application of existing knowledge requires new professional attitudes, accepting that the aims of primary care must be set by public health, not just the sum of all personal complaints, and that primary medical generalists are a subset of social workers, not a separate species. Those are necessary but not sufficient preconditions for full application of knowledge. To these must be added appropriate resourcing, so that teams working at the deep end have the staff time needed to work at least at the same pace as their colleagues serving more affluent populations. Outlines of this strategy have been developed by Graham Watt's Deep End project, from experience of staff in practices serving the 100 most deprived communities in Scotland (19–22).

This implies a major shift in resources toward areas with greatest needs, comparable with that achieved after 1948, with equal doctor/patient ratios throughout the UK – both substantial redistributions of wealth. If, as it surely must, this were accompanied by recognising the role of patients and communities as active participants rather than consumers, it would also entail a redistribution of power. Such mighty shifts would depend on two necessary elements now wholly absent: first, a level of political will and understanding not seen in Britain since the high days following victory in1945 – victory not only over fascism, but over all the complacent assumptions of our ruling class, by a furious tide of popular discontent resulting in a landslide vote. Secondly, it would require an expanding rather than stagnant or contracting NHS staff workforce, so that redistribution of resources could proceed through selective expansion, rather than by reducing resources which less impoverished communities already have. Any such development would require social solidarity across presently assumed class divisions, a new broad alliance. No such dual earthquake is currently anticipated or welcomed by any established UK political party.

Prospects for earthquakes

However, earthquakes do happen, and at unpredictable times. There are necessary, but not sufficient, preconditions for big earthquakes. There must be huge rising tensions beneath the visible surface, potential cleavages waiting to spring apart, furnaces waiting to explode. Such tensions have long been obvious. Since accurate data became available in 1929, real wages of

a majority of the employed US workforce never fell until 1973. Over the following 20 years they declined by 11%. Entry of wives into the workforce kept median family incomes rising more slowly until 1989, but even median family incomes then started to fall, by more than 7% from 1989 to 1993. The US became not only the most unequal industrialised society in the world, it also grew more unequal faster than anywhere else, with the UK close behind (23). Such reality as there ever was to sustain the American dream that anyone who worked hard could get rich, vanished long ago. The dream still continued until 2007-8, only sustained by a new and even more profitable industry; lending to people in deepening debt, and borrowing from China to pay for imported goods from the world's cheapest industrial workforce, largely created by US, UK and EU investment, and destroying their own manufacturing base. Corrected for inflation, average hourly wages in USA in 2000 were still 8% lower than their level in 1973, 27 years earlier, and 40 million citizens had no health insurance. In 1970, average household income for the richest 5% was 16 times as much as for the bottom 20%. By 2000 this difference had increased to 25 times as much. In 1970, average earnings for Chief Executive Officers exceeded average pay in their workforce 39-fold. By 2000, this difference had increased to 1000-fold (24). Finally, by the eve of the world banking crisis of 2007-8, average household debt was 20% higher than disposable income in USA, and 40% higher in UK (25).

The first tremors of an earthquake are now upon us, with a global financial crisis since 2007-8 which threatens to be even more profound than the global depression starting in 1929, which was ended only by preparations for the second world war. All the causes of this new earthquake remain in place. Far from diminishing them, the treatments so far proposed by all the main political parties are more likely to reinforce those causes.

So far, no other treatment has seemed available. People and ideas which caused the crisis retain dominant power, because no coherent or credible alternative seems to exist.

People learn only from their own experience

Until they happen, only seismologists really believe in earthquakes. Then, when a global socio-economic earthquake occurs, people must look for some way to make sense of it. The first, most readily available ways to make sense will always be irrational, because no rational explanation has a public hearing within the established paradigm.

Beginnings of an alternative paradigm have in fact been on the shelf for at least 130 years, with more explanatory and predictive power than either

the simple but honest ideas of Adam Smith in 1762, or any of the increasingly tortuous sophistries derived from them since. Karl Marx's analysis of the social relationships of production and capital investment provides the beginning for any rational analysis of capitalist economy at any stage of its development, in the same way that natural selection provides the beginning for any rational analysis of development of species. Marx's analysis of capitalism in mid-19th century Britain is not sufficient for useful analysis of global capitalism 150 years later, but this is the beginning. And it is hardly any guide at all to socialism which lay in a future yet to be discovered in practice. Those who exclude Marx from the mainstream of developing socio-economic analysis are as absurd as biologists who try to exclude Darwin. Marx's analysis of social class, derived from the social relations of production and ownership and control of capital, have in every way been reinforced rather than weakened by historical experience.

This includes the impossibility of building sustainable socialized human relationships on industrialized commodity production essentially unchanged, as in the USSR and China, a fact brutally denied by the dominant guardians of Marxism from 1917 to 1990. Socialized human relationships begin to be feasible only when commodity production has already reached a level of abundance, and burdens of over-production, under-consumption and unemployment are imposed on whole populations, locked into industrialization and with no means of escape to subsistence economy: obvious poverty alongside obvious potential wealth, in a literate population, and in a country able to defend its independence.

In North America, Western Europe, and Australia that point was reached in the early 1970s. In all these areas, potential foundations for socialist society now exist. Their populations lack only the understanding .and confidence they need to make use of them.

All these areas, particularly those furthest into a post-industrial phase of development, now face growing structural unemployment on a scale not seen since the 1930s. Advocates for a capitalist economy, in which production for use is only a byproduct of production for profit, celebrate the creative destruction of periodic crises, as necessary preparation for a new round of expansion. Each crisis of overproduction prompts elimination of old, more labour-intensive industries. Each recovery replaces these with new, less labour-intensive industries. Productivity rises, and more people become redundant to the commodity production process. Economic recovery, measured by profit for shareholders and salaries, bonuses and pensions for top executives, will therefore become increasingly dissociated from social recovery, measured by real wages, stable employment, and non-com-

modity production in homes, communities, and public services developed as extensions of this value production outside the market(26). To restore even sufficient stability to maintain profitable commodity production as it was, people discarded from old industries and redundant from new ones must be allowed some creative role in society, recognized by dignified earnings, health care, and improving education for their children.

The obvious areas for expanding employment are health care and education, in which productivity (measured by outcome) rises as they become more labour-intensive, not less. Both these fields of production resolve the division between providers and consumers essential to commodity markets; their productivity depends on that resolution. So these fields of activity should expand at the expense of commodity production for profit. They are also essential to the social stability necessary for profitable and sustainable commodity production to continue. All the factors necessary for first steps toward transition from a capitalist society to a socialist society therefore already exist in the fully industrialized economies now in crisis. All that is still lacking is recognition of this opportunity, by the large majority of people who could gain from it.

Such recognition is held back by ignorance and fear. Ignorance is becoming hard to maintain, now that virtually everyone can read what they want through the internet. Fear is founded mainly on past experience of attempts to found socialist societies, all of which failed to move beyond the command structures necessary to create and defend them in undeveloped economies, not at the end of capitalism, but at its beginning. Interestingly, there are just two fields in which this primitive command socialism was remarkably successful, health care and education. But for commodity production they failed, replacing the despotism of competing employers by the more powerful despotism of coercive states.

Democratic socialism will depend on a level of responsible and critical citizenship far beyond the grasp either of credulous consumers at the bottom of capitalist society, or of casino players at the top. Education, health care, and the arts and sciences which support them provide spaces in which everyone can learn how to evaluate evidence, take rational decisions, and learn from their mistakes, within rules of behaviour that respect and value diversity of opinion. If they have any self-respect at all, people who call themselves democratic socialists should be able to conceive of these fields as potentially liberated areas within capitalist society, growing within a culture wholly distinct from the culture of business, and aiming to replace it (27).

Possibilities in the British Isles

The only major progressive step undertaken by Blair's New Labour administration was creation in 1999 of regional parliaments in Scotland and Northern Ireland, and an Assembly government in Wales. These all have administrative and policy powers over education and the NHS. Except in Scotland, they have no control of taxation, and all still depend on allocation of resources from central government in London. This central power will certainly be used, by a Conservative/Liberal Democrat government wholly committed to a NeoLiberal agenda, against regional governments all more or less committed to the old Social Democratic agenda. Projected NHS per capita spending is already planned to fall by 2013-2015: in England by -0.9%, in Northern Ireland by -2.2%, in Scotland by -3.3%, and in Wales by -10.7%, despite an expected rise in the costs of care exceeding general inflation, and ageing populations. Civil servants in Wales and Northern Ireland (but not Scotland) still pursue their careers on a UK stage, influenced more by attitudes in England than by any rebellious views at the periphery. Finally, only Scotland has a really powerful political party independent from any party in England. Parties in Northern Ireland are still hopelessly divided on religious sectarian lines. Plaid Cymru in Wales has failed to take root outside the 20% minority who speak the welsh language. The Welsh and Scottish Labour Parties have not hitherto dared to break openly with the predominantly English UK Labour Party, which has still not renounced the Neo-Liberal policies of New Labour in office.

Despite all these *caveats*, fundamental steps have been taken in all three Celtic regions, away from the Neoliberal agenda. In 2005, Prof. David Kerr, chair of National Framework Advisory Group set up to plan NHS Scotland over next 20 years, made it clear that the English NHS reform agenda of choice and competition would not be followed, and indicated a marked shift from hospital to community care, reducing need for hospital admissions (28). In 2008 health ministers from Scotland, Wales and Northern Ireland launched a joint attack on London government about NHS pay negotiations taking place behind their backs, and issued a joint communiqué affirming their support for principles of an NHS firmly in the public sector, and that all national ministers must be involved in any definitive negotiations on staff pay (29). All three regions have taken practical steps since then to eliminate the purchaser-provider split, established in 1990 as a foundation for eventually full exposure of the NHS to market forces. All three have abolished all prescription charges, which in England now stand at more than £7 per item for all except groups exempted by age, specific disease, or destitution. In Scotland, where both private education and pri-

vate medical practice have always been weak, MPs in the Scottish parliament (MSPs) have voted to make it illegal for any commercial organisation to run any part of NHS primary care. Answering Conservative MSPs who claimed that independent contractor status of GPs showed that primary care was already privatised, so commercial operators would make no difference, Nicola Sturgeon, health minister in the Scottish Nationalist government, replied that of course GPs were already independent contractors, but they were also directly involved in frontline delivery of care. "The problem of existing law", she said, "is that it leaves it open to a health board to award a contract to a body in which none of the individuals are registered medical practitioners or healthcare professionals." (30)

Scotland is even committed to the Glyncorrwg model of anticipatory primary care (31). This is as yet only an unresourced aspiration. So far, none of the UK regional governments has actually redistributed wealth or power in the NHS on a significant scale, to address gross inequalities in health. Wales, ruled by a Labour Assembly government nominally bound to the policies of its central UK Party, has in practice pursued policies directly opposed to central leadership, but so quietly that even in Wales most people are hardly aware of the growing difference between NHS Wales and NHS England. As the chief opposition in the London parliament, Labour has yet to oppose Conservative policies in principle, and is obviously evading any commitment to reverse them if it regains power. This position is still endorsed by most Welsh Labour MPs, though not by Members of the Wales Assembly.

Those are the weaknesses, and they are serious. All three Celtic nations face much heavier burdens of sickness and care workload than England, all three face diminishing budgets (much worse in Wales), none of them as yet show much evidence of any return to political awareness and activism, and the general fear of impending mass unemployment seems so far to have had a paralysing rather than spurring effect. By July 2011 UK unemployment reached 2.51 million (7.9% of the workforce) and is still rising. It is worst in the young age group 16-24 at 973,000, more than three times the rate for all adults (32). In Wales unemployment reached 8.4% of the workforce by January 2011, about the same as in Scotland and Northern Ireland. This was similarly concentrated in the 16-24 age group, at about 22% of the workforce. On the other hand, union membership, at 38% of employed workers in Wales, 35% in Scotland, and 39% in Northern Ireland, is substantially higher than England's 28%, and both Wales and Scotland can look back to strong traditions of radical dissent (33). In Scotland, all the running has been made by the Scottish National Party in government, with the Scottish Labour Party scarcely to be seen.

With such weak foundations in principle and in public awareness, some other explanation is needed for the firm stand taken by governments in all three Celtic regions. Probably the most powerful force stimulating resistance has simply been the obviously impossible cost of following the English example, at a time of rapidly increasing austerity. Prof. Allyson Pollock estimated in 2009 that if NHS England followed Scotland and Wales by abandoning the NHS internal market, and returned hospital and primary care Trusts to control by area planning authorities accountable to elected government, it could save between £6bn and £24bn a year (34). The wide limits of this estimate derive from the fact that since 1991, when the internal market began, neither Conservative nor New Labour governments had published, or perhaps even known, or wanted to know themselves, the additional costs incurred by billing, invoicing, enlarged finance departments, marketing, management consultants, lawyers, and commercial contracts.

What about our assets? Unlike Scotland or Northern Ireland, the Labour Party is in government in the Wales Assembly, in control of NHS (and educational) policy. The Labour Party in UK is profoundly divided. The present leader, Ed Miliband, was narrowly elected in a contest with his brother David, mainly because of trade union support. He is an unconvincing, vacillating leader, who looks ever less likely to be electable. Brother David represents continuity with Blair and New Labour, and lost the trade union vote for that reason, but he is a much more confident and therefore convincing leader. Like Blair, he looks very electable. If and when Ed's leadership is challenged, the right wing of the Party will endorse David. Almost certainly, the left will then support the present shadow finance minister, Ed Balls. He is a vigorous performer in parliament, who is clearly moving left and positioning himself for leadership. As voters begin to suffer the full consequences of the present Conservative/Liberal Democrat coalition's slashing attack on all benefits and welfare institutions as well as on higher education, there will certainly be a massive politicisation of the middle and working class electorate: probably most will move to the left, but at least some will move toward neo-fascist groups. In this situation, Wales could become a much more important player in UK politics, as the only region where Labour holds power, and can defend and develop further the NHS as a socialising part of our economy. By the time of the next general election, Wales could be the only area with concrete experience of applying democratic socialist principles to real people in real communities, learning as we go. As the NHS is still the most loved UK institution, those who betrayed it could pay a heavy price at the next election, and those who

defended it could make corresponding gains. This could be a powerful influence on MPs and shadow ministers.

Everything will depend on whether Welsh political leaders, and Welsh medical and nursing professionals, recognise these opportunities and rise to this occasion. On this question, the jury is still out. We have several very strong political players among Labour members of the Assembly (mostly women) and in the Wales Assembly government, though weaklings and vacillators are still well represented. They won't lead, but as the heat rises, they may follow.

Finally, in spite of everything, medical science and professional thought will continue to advance, continually adding to our long-term advantage as advocates of open and evidence-based rather than covert and populist policies.

Of course, we may fail. Even then, there will still be the more civilised countries of Scandinavia to fight for a more human world. One way or another, we shall win.

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