Events have confirmed all the main trends suggested in the first edition of this book, published in 2006. The worldwide drive to reshape health care away from public service towards commercial models, with varying support from the state and participation by for-profit corporate providers, has become a dominant government strategy virtually throughout the world.

The US has been the prime mover, but as its own commercial health care market becomes an ever more spectacular failure, its salesmen have had to look elsewhere for evidence to support their claims. UK governments, first Conservative, then New Labour, offered our National Health Service (NHS) as the most influential site for their experiment. This would, they believed, surely demonstrate the immense gains, in quality of service, value for money and staff productivity, to be expected from market competition, consumer choice, industrialisation and motivation by profit. Unfortunately commercial secrecy, and the natural reluctance of governments to admit even the possibility of error, precluded any systematic collection of data to provide conclusive evidence either way.¹ So we must judge as best we can, from the medical, public health and administrative literature, from the more responsible parts of our news media, and from colleagues we know and trust. Judging from these, spending money on health care by putting it into the pockets of commercial providers has at best not improved care any more than we might have expected from spending the same money directly on previously existing public service. At worst, it has inflicted serious damage on staff morale, and on patients’ understanding of care processes. Commercialised, competitive, marketed care still has powerful advocates, who assure us that their medicine will eventually work, if only we would swallow a bit more of it. They hold political power which they will continue to use as long as they can.

Early in 2008 deregulated financial markets collapsed, starting in the US and the UK, the countries whose rulers had been most devoted to solving all problems through market competition. Blind faith in the profit motive, which sets simple personal greed as proxy for complex social wisdom, caused that collapse. At that elementary level, millions of people all over the world are already approaching a consensus view, learned from their own experience. They now know that experts accepting millions a year in exchange for their integrity

---

¹
and devotion to public duty no longer possess these qualities. People have rediscovered that they must think for themselves – above all, those with least power in society.

The world has entered a period of crisis unprecedented in history. We have a conjunction of three simultaneous global crises: a crisis in the global trading economy, a crisis in the climate and resources of the natural world, and a crisis in ideas that have subordinated every human activity to the single supreme aim of accumulating wealth in a small dominant fraction of society, measuring our worth not by what we are able to do, but by what we are able to consume. Much of the crisis in health care arose from this context, so from change in this context we should look for solutions.

The four years since the first edition have confirmed my belief that from study of the NHS when it operated as a gift economy from 1948 to the early 1980s, and of the first shoots of new relationships between staff and patients which developed over that time, we may find the beginnings of economic, political and cultural alternatives to the state we are now in – not just for health care, but for society as a whole.

**Changes in this edition**

As in the previous edition, this book is designed to be readable at two different gear speeds. The main text tries to present a coherent argument, with empirical data to support and illustrate this restricted to a (fairly generous) minimum. The notes and references provide a lot more empirical evidence and discursive argument and opinion.

I have never worked from a full-time academic base, so my analysis could draw on personal experience of actually providing primary health care, in relatively difficult circumstances, over a lifetime spent mostly in one place, with the same population, and reading some of the main English-language journals every week. From these I took evidence that seemed relevant to my own work, as a generalist with responsibility for primary care, and referral to specialist care, for a community of around 2,000 people, mostly coal miners and their families. The aim of medical care for a population is to change its experience of illness. We have more than enough books derived chiefly from other books, but we are desperately short of new ideas derived from real experience of planned social change of any kind.

However, though high theory can start from low practice, to be generally useful, it can’t end there. Real economists and real sociologists must develop the theme of co-production in a gift economy as I think it deserves. Perhaps this process has already begun. Equally, I cannot
write with authority about specialist areas of care, or about reintegration of generalist and specialist care, an important issue badly in need of development not in the heads of academics, but, combining theory with experimental practice on the ground, by a younger generation of innovators. All I can do is to indicate some examples of the sorts of development such reintegration might need.

Mine is a view from below, from the coal-face, not from the boardroom. That has some great advantages, but also some serious weaknesses. I am ashamed to admit that I only got round to reading Charles Webster’s splendid short history of the NHS in the last weeks of writing this second edition. His masterful overview, together with the more recent work of John Lister bringing it up to date, is more competent than anything I could achieve, but these are views from above, albeit from an essentially socialist perspective. I was working at what was then the base of society. There, at the point of production, I then believed was the main source of power for fundamental social change in a forward, civilising direction. However, a view from below is in important ways incomplete. Webster’s book made me re-read everything I had written, and already revised many times.

Finally, I must apologise for being a very old man, now 83, writing on a subject that needs a much younger author, more familiar than I can possibly be about recent practical developments in clinical medicine and the organisations, reorganisations and re-disorganisations of the NHS, and still working inside it at some typically overworked and under-resourced point of production. No such paragon seems to be currently available, so I have done the best I can. To compensate for not being able to provide as much up-to-date empirical data as I think my argument deserves, I have given readers a lot of interesting older stuff with which few are likely to be familiar. It is often useful to look at the beginnings of new ideas, and not always easy to find them, even with the internet.

Why political economy?

Political economy is not normally an attractive subject for students of health care, or for most people concerned with the NHS as users, though both are my intended readers. In fact quite the opposite: at least since the late 1970s, whenever most economists have commented on health care, it has been to explain what cannot be done. Alan Maynard actually defined health economics as the study of choices in conditions of scarcity. The founders of economics, William Petty and Adam Smith, took a more positive view, never detaching economics from politics.
Smith’s *Wealth of Nations* started from analysis of contemporary production. He was more concerned with expanding productivity than with defining its limits, and had no illusion that economics could ever become a socially neutral, apolitical technology.

Students find applied human biology hard enough by itself. Adding political economy may seem only to make this study even more difficult, and even less human. They are unlikely to face any overtly political or economic questions in their examinations, and in their subsequent professional lives most of them plan to stay as far as possible from both. I understand how they feel, but people who turn in disgust from either politics or economics leave the field clear for careerists who see little wrong with either of these two corrupted fields as they now are. Events are revealing the consequences of this abdication from the responsibilities of citizenship. If we want our children to lead civilised lives, the world will have to change course, away from competition toward cooperation. We know already who will resist that change, but who will promote it, and how? The first step must be to understand where we are, how we got here, and where else we might go, using available empirical evidence. We have to start not from where we might like to be, but from where we are. And we must start not with the people we might prefer, but with those we have.

Media discussion, and much professional discussion, has long deplored the apparent dehumanisation of care, ‘getting better but feeling worse’. This unease seems to have grown alongside the exponential growth of science-based care over the past 50 years or so. Assumptions that science is somehow itself a dehumanising force are now commonplace. Analysis of functional relationships between staff and patients in the continuing processes of care show that this perception is false. Where these relationships are allowed to escape from a provider–consumer model to cooperation in a gift economy, where health care functions as cooperative production of real wealth rather than as competitive production and consumption of commodities, long-standing traditions of mutual trust can be recovered, expanded and sustained. Such beginnings could be developed as foci for rebirth of community and social solidarity in otherwise disintegrating societies.

My central argument is that commerce (and the forms of industrialisation produced by commerce) is inappropriate to this area of wealth production. For production of almost all objects, and many if not most simple services, profit motivation, extreme division of labour, and eventually replacement of human labour by machines, has led to order-of-magnitude gains in productivity, even though these processes have in many ways dehumanised labour, misdirected investment and
degraded our planet. However, for production of objects and some personal services, it can still be claimed that human and environmental losses may be outweighed by gains in productivity, at least if pursuit of profit is strictly limited by state regulation. Production of health gain through medical care presents an entirely different picture. In this field, commercialising and industrialising processes are a confusing and destructive force. They deflect, deform and ultimately demoralise staff motivation and imagination; they shift the directions of investment from what is most needed by people to what is most profitable for business executives and impatient investors; they limit the imaginations of researchers in medical science; and they invite corruption and fraud.

Why Wales?

Wales is a small country, with fewer than three million inhabitants. And so is Great Britain, centre of a once mighty world empire, but now barely even a second-rate power, its manufacturing base largely eliminated through investment elsewhere, its financial sector inflated beyond all reason, making us more vulnerable to speculation than any other major economy. From experience of so small and atypical a base, it may seem impertinent to write a book about global principles. And so it may seem to write about the whole of medical care from experience limited almost entirely to a small coal-mining community in the course of losing its main justification for existence.

One has to start somewhere. Why not from experience of organising innovative care for real people in a real place, for most of a real life, which fortunately coincided with the birth of the NHS, the death of coal-based industry and the first signs of a new, knowledge-based economy? I entered practice in 1952, when the new service was just beginning to find its feet and when conditions and methods of work had hardly changed since the late 19th century. I have therefore experienced virtually the whole life of the NHS so far, both its advances and its retreats, as well as the expansion of applied medical science from a small fraction of practice at the beginning, to almost total dominance today. That perspective is a useful safeguard against over-confident assumptions about the future, and as good a way as any to look at reality as wider views from further above. We need both.

I realise that experience in countries exposed to the full force of privatisation of all public services – including experience of state and civic violence, for example in Argentina, Chile, Russia, Poland, Greece and many parts of Africa and Asia where the International Monetary Fund, the World Trade Organization and the World Bank have imposed
the beliefs of the Chicago school of economists without regard to local history or opinion – might provide a more compelling narrative. In some of these countries, this process has been a matter of life and death, not just in hospital beds, but in streets, prisons and torture chambers. I have not shared those experiences, so I can’t write those books, and excellent ones already exist. 5 On the other hand, Wales is where the ideas underlying the NHS first began. For several decades after the Second World War, the NHS provided the main model for state-funded and state-owned free health care services in other industrially developed economies. Because the frankly commercial health care system in the US is regarded by most people in other countries as a market failure, the authority of the NHS has been used as the main platform for export of ideas for so-called ‘reform’ of public health care services throughout the world since the 1980s. Britain was the birthplace of industrial capitalism, where privatisation of common land first created an industrial working class, entirely dependent on employment by owners of industry. The iron- and copper-smelting and coal-mining valleys of South Wales were its cradle. These valleys were the first to give birth to prepaid health care as a locally controlled public service, funded collectively according to ability and provided free according to need – the first step on a road leading ultimately to the NHS.

Coal mining in Wales is now virtually extinct, and even steel production faces an uncertain future. We are now well into what seems to be the next, and possibly final, stage of capitalism – post-industrial society, in which people are losing their pride as producers. They are sinking into a humiliating social role as passive consumers, compelled either to rediscover a new basis for social solidarity or to perish in attempts to retrieve an illusory imperial status they have already lost. In Wales we have endured every phase of this apparently universal sequence. We may provide as good a place as any to look for whatever comes next.

Wales has a rich tradition of radical thought and action, barely visible today, but not wholly forgotten. The partially autonomous Welsh Assembly government, together with the regional governments of Scotland and Northern Ireland, has taken first steps towards reversing the policy of commercialising health care, in which central government, always obedient to the commands of transnational wealth, still stubbornly persisted through three New Labour administrations. Their successor, the Conservative–Liberal coalition, is now going full tilt down the same road.

Wales was the birthplace of the NHS. If the Labour–Plaid Cymru coalition in the Assembly holds its nerve, Wales could be the
battleground for its future. The labour movement in Wales can still distance itself from the fraudulent ‘New Labour’ experiment, get back on track towards democratic socialism, and discover what this slogan could mean in practice, through an NHS within a truly plural post-industrial economy, with a strong culture of public service, and renewed commitment to solidarity. I am not trying to see beyond that.

Truth is concrete. I suspect that the very elementary conclusions drawn from a small base in this small country can mostly be applied in outline elsewhere, at least for a start, and providing that huge international differences in history and culture are always borne in mind. For this last reason, I have presented the early history of primary medical care in Wales in some detail, to demonstrate the sort of evidence needed anywhere to understand what is locally possible, and to encourage others to find their own path from their own origins.

The many friends and colleagues who helped me with constructive criticism of the first edition were thanked when it appeared in 2006. I am extremely grateful to Tony Benn, Graham Watt, Ben Hart, Tony Beddow, Stevie Stevenson and Andy Tate for their generous and tolerant help with this one.

Julian Tudor Hart
July 2010
julian@tudorhart.freeserve.co.uk
www.juliantudorhart.org