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# *'Public Knowledge' and Health Policy*

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## Introduction

Aeron Davis' succinct overview of the contemporary determinants of the quality of public knowledge provides many of the elements needed for understanding what has happened to public knowledge about health policy since 1980. But knowledge about health care is not merely subject to the general impact of global market forces outlined by Davis (the internet, inequality, neoliberal ideology, austerity, the audit culture), and the increased complexity of modern knowledge. Being almost entirely state-funded in Britain, and therefore a prime object of state policy, health care is also subject to a critical shift that has simultaneously taken place in the way policy is made. The end of the hegemony of social democracy in the UK in the late 1970s saw the end of the liberal/social democratic 'policy regime' that had been in place since the 1920s, if not earlier.[1] The neo-liberal policy regime which has replaced it effectively rejects – in intention and increasingly in practice – the concept of a 'public sphere', to which the concept of public knowledge is necessarily linked, and this is nowhere more evident than in relation to health policy.

## The institutional foundations of the public sphere

The 'public sphere' was above all a construct of the institutions through which social, economic and political knowledge was produced and assessed, and policies were endorsed, independently of the influence of private interests. These institutions were the professions, insulated from both commercial pressures and from government; the universities, funded through arms-length arrangements to preserve their freedom to do disinterested teaching and research; press freedom, to allow for the exposure of official dissimulation or lies; public service broadcasting, to give the electorate valid information and a platform for public debate on how it should be interpreted; judges, funded from the civil list to make them able to stand up to governments; and the senior civil service, dedicated to ensuring that policy was made in light of the public knowledge made possible by these arrangements.

The idea of a public sphere was closely linked to the idea of the public interest. At a minimum, the concept of the public interest is something distinct from, or which transcends, private interests, and involves commitment to a norm of disinterestedness; but it could also connote substantive values, such as that human happiness should be maximised, or that everyone should be as healthy as possible, etc. As soon as this is acknowledged it is obvious that the idea that 'public knowledge' is something universally shared is inherently problematic. At any given time there is typically a body of conventional wisdom, the dominant ideas of the day, which can be described as shared. But this set of ideas is always contested; and in the case of health what we are witnessing is a drive to devalue and if possible eliminate a former body of received wisdom and replace it with one in which, instead of policy being produced in the public sphere to serve the public interest it should be produced by whatever means will simply make markets efficient. Rupert Murdoch's statement, in relation to broadcasting, that 'the public interest is what interests the public' was a fair representation of the neoliberal viewpoint: the elite who have occupied the key roles in the public sphere are unrepresentative and their claim to uphold an interest shared by

[1] This is outlined in my essay 'The Cynical State' in Leo Panitch and Colin Leys (eds), *Telling the Truth: Socialist Register 2006*, pp. 1-27.

everyone is undemocratic and invalid. The only valid ground for any statement about interests is consumer preferences.

**Dismantling the public sphere in health policy**

The NHS was a priority target for neoliberals for several reasons. First, accounting as it did for about 15% of state expenditure, it was seen as a potentially major field for private capital accumulation. Second, being tax-funded and equally accessible to all it was a bastion of social-democratic values and a constant reminder of the advantages and popularity of non-commodified services. Moreover since there is a steep class gradient in ill-health, spending on health care necessarily also involves some income redistribution from rich to poor, not just from the well to the ill. For all these reasons the NHS was one of the first branches of the state to feel the effects of the new neoliberal policy regime beginning with a radical reorganisation of the Department of Health (DH).

The erosion of the Department's policy-making function has been the most complete of any government department. Since the creation of the NHS Executive in 1989, which shifted effective power over policy more and more into the hands of health service managers, the DH has been steadily run down, declining from 4,795 staff in 1996[2] to 2,422 in 2013, of whom only 164 were in the senior civil service[3], and almost all of these had been recruited from hospital management or, increasingly, from private sector sources, especially management consultancies. Of the 32 members of the 'top' team in 2006, 18 were drawn from NHS management and 6 from the private sector; only one was a career civil servant.[4] And from 2003 to 2010 a 180-strong Commercial Directorate, consisting almost entirely of 'interims' seconded from the private sector, infused the DH with a market-oriented culture, while senior DH personnel moved in the opposite direction, into senior jobs with private health companies, as did several former Labour ministers following the 2010 election.[5]

In this way the defence of the public interest in health policy that was formerly provided by the senior civil service's role in policy-making was effectively abolished; instead, during the years 2000-2010 the development of health policy was in practice largely outsourced to a mixture of management consultancies and two well-funded think-tanks, the Kings Fund and the Nuffield Trust, the latter of which had strong ties with the private sector. McKinsey and Co. in particular played a major role in Labour's health policy thinking in those years, and is credited with shaping much of the detail of the Coalition's 2012 Health and Social Care Act.
A further effect of the market-creation drive was to reduce the amount of information on the basis of which policy can be evaluated. For example details of how the £60+bn a year, now channelled through Clinical Commissioning Groups (CCGs) to pay the providers of secondary care, is spent are no longer centrally collected.[6] Moreover most CCGs have

[2] http://www.civilservice.gov.uk/wp-content/uploads/2011/09/css97_tcm6-2540.pdf
[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/390893/DH_WMI_Nov-14.csv/preview
[4] Scott L. Greer and Holly Jarman, *The Department of Health and the Civil Service*, The Nuffield Trust, 2007, Table 1.
[5] The revolving door in health policy is discussed in Colin Leys and Stewart Player, *The Plot Against the NHS*, The Merlin Press 2011, pp. 90-95, and the revolving door as a mechanism for the abolition of the civil service as a bastion of the public sphere generally is discussed in Colin Leys, 'The Dissolution of the Mandarins: the sell-off of the British state', Open Democracy: OurKingdom, 15 June 2012, https://www.opendemocracy.net/ourkingdom/colin-leys/dissolution-of-mandarins-sell-off-of-british-state
[6] See for example Lord Howe's reply to Lord Owen: HL Deb, 12 May 2014, c463W, cited at http://www.theyworkforyou.com/wrans/?id=2014-05-12a.463.3

outsourced the making and management of the contracts for these services to Commissioning Support Units (CSUs), embryonic management companies formed by the remaining staff of the now disbanded PCTs, with the effect that many details of the expenditure of even a single CCG are not obtainable by public researchers. The combination of these factors means that the information needed for the critical evaluation of the outsourcing of acute and community care scarcely exists.

These developments in health policy took place in the context of another general development in the erosion of the public sphere: the normalisation of spin.[7] The advent of new techniques for influencing public opinion coincided with the arrival in office in 1997 of a Labour leadership determined not to allow the right-wing press to repeat the savaging that had been meted out to the party between 1981 and 1992. In office the party invested heavily in media management. Government publications became like corporate publications, designed to convey positive feelings and downplay bad news; Lord Darzi's 2008 report on healthcare for England, to which McKinsey staff also made a large input, was a prime example of this style.[8] Another was McKinsey's 2009 report on 'Achieving World Class Productivity'.[9] This report, in the form of power point slides, called for a programme of 'efficiency savings' based on manifestly unrealistic assumptions and financial projections for which no accessible sources were provided. Yet it became the basis of policy, whereby NHS managers were called on to maintain or even improve services while losing £20bn in funding over five years. By 2010 no one seriously concerned with health policy any longer placed great confidence in the value of statements or claims emanating from the DH.[10]

As for the production of public knowledge by the fourth estate, the negative pressures itemised by Aeron Davis apply in spades to health policy. Health policy is complex and undramatic, and unattractive to editors at a time when newspapers are desperate to stem the loss of readers, while simultaneously cutting editorial staff and making those who remain work longer and across more media. The temptation to rely on government press releases is nowhere stronger than in health policy.

On top of these general pressures there is the threat to public service broadcasting represented by the demand from private broadcasters for a slice of the television licence fee. Following the brutalisation of the BBC by Alastair Campbell for exposing the Blair government's duplicity over the 'dodgy dossier' on Iraq, successive Directors General and BBC trustees seem to have concluded that the corporation's future depends on recognising that the mid-point of the party political spectrum has moved decisively to the right. How far the BBC's startlingly uncritical treatment of the 2011 Health and Social Care Bill was conscious policy, as opposed to the more or less unconscious internalisation of the new ideological reality by senior BBC staff, it is impossible to say. As Oliver Huitson notes in his review[11] of the failure of the media to provide a critical understanding of the Bill, the real aim of the legislation was too obvious to be overlooked and a very large gap opened up between the mainstream discourse on health policy and that of the social media. This raises an interesting question: in

[7] See Tamasin Cave and Andy Rowell, *A Quiet Word: Lobbying, Crony Capitalism and Broken Politics in Britain*, Bodley Head 2014, ch. 4.
[8] *High Quality Care for All: NHS Next Stage Review Final Report*, 2008.
[9] http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_116521.pdf
[10] On official mendacity about health policy between 2003 and 2010 see Leys and Player, *The Plot Against the NHS*, ch.8.
[11] 'Hidden in plain sight', in Jacky Davis and Raymond Tallis (eds.), *NHS SOS*, Oneworld 2013, chapter 6.

the era of globalised capitalism, how far does the operation of representative government need shared public knowledge? Do voters increasingly expect to be told nothing they can really trust, and how far does their resulting indifference pose a significant threat to the legitimacy of the government and the representative state?

Two other notional pillars of the public sphere have proved fatally weak in relation to health policy: the medical profession, and academic experts. Mrs Thatcher's view that the professions were market-constraining monopolies that needed to be brought to heel led to a new culture of criticism and to considerable inroads into the independence and prestige of doctors. In 1945-6 the BMA had come close to refusing to operate the new health service; in 1987 the presidents of the three biggest Royal Colleges of medicine took an opposite stand, this time in defence of the NHS, writing a joint open letter to the Prime Minister protesting against the financial strangulation to which the NHS was being subjected. By 2010-12 such confident behaviour was no longer thinkable. The BMA and the Academy of Royal Colleges were in a position to make it politically impossible for the Coalition to push through the HSC Bill, and over the months from July 2010 (when the White Paper outlining the Bill was published) to the Bill's passage into law in 2012 a majority of doctors became more and more opposed to it. But their leaders refused to adopt a position of categorical opposition, or to actively communicate their members' views to the public. Among many possible explanations the most likely, as well as the most charitable, is that the leaders were ultimately more committed to the interest of the profession than to that of the public, and judged that they could not afford to lose government patronage.[12]

As for health policy academics, there too there is now an alignment of interest towards government policy rather than to the public interest. The conversion of universities into institutions primarily concerned with producing trained manpower for corporations and research useful for making money has been underpinned by their reconfiguration as businesses.[13] Research funding from the Economic and Social Research Council is explicitly oriented to the promotion of economic competitiveness, and much academic work on health policy is directly financed by the DH.[14] There is strong pressure from university administrators to secure research grants and there are few charitable funding sources that are not themselves aligned with government policy. In this context few academics working on health policy, even among senior tenured staff, have been willing to become outspoken critics of the market-based model, even though both theory and empirical research show that in health care market-based provision leads to higher costs and lower quality. The pages of health policy journals contain plenty of critical analysis of particular health policies, but it is mainly 'immanent' criticism relative to the expressed aims of policy, rather than critique based on any alternative conception of how the public interest might be served.

## Conclusion

In conclusion, rather than seeing the issue in terms of the existence or non-existence of shared public knowledge, I am inclined to see it more in terms of competing visions of the public interest, and competing knowledge paradigms derived from these; and to question how far the 'sufficient legitimacy' of election-based governments now depends on the paradigm favoured by the government of the day being widely shared. What is clear, though, is that in health

[12] See Jacky Davis and David Wrigley, 'The silence of the lambs', in Davis and Tallis (eds), *NHS SOS*, ch. 4.
[13] Andrew McGettigan, *The Great University Gamble*, Pluto Press, 2013.
[14] In 2012-13 the DH spent almost £240m on policy research: see *Annual Report and Accounts 2012-13, Annual report and management commentary*, paras 2.38-39.

policy the conditions for the maintenance of a concept of the public interest independent of politically dominant private interests have been largely destroyed, and with them the possibility of any coherent public discussion of health policy.

To take just one of many possible examples, consider the issue of cost, which is currently at the top of the election agenda. The question asked is whether the NHS is 'affordable'. But affordable by whom, and with reference to what standard of reasonableness? In relation to the present government's austerity spending plans? Or to the proportion of GDP spent on health, which remains so much lower than that of comparable countries?[15] How valid are the assumptions underpinning the claim that the NHS faces a £30bn financial shortfall? What portion of this predicted shortfall is accounted for by the administrative and legal costs of operating the service as a market, compared with those of non-market provision? What evidence is there that the costs of opening the NHS up to competition from private providers have been offset by increased efficiency? How far is the problem one of the scale of the resources needed, as oppose to resistance on the part of wealthier taxpayers to raising the needed resources from taxation? Given the stakes these are not unreasonable questions, but even if there was a shared willingness to seek objective answers to them neither the data required, nor adequate resources to study them, any longer exist.

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[15] See the 2014 Barker Report, which pointed out that with very limited increases in spending on the NHS 'By 2025 England's public spending on health and social care combined would barely match what comparable countries spent 15 years earlier': *Commission on the Future of Health and Social Care in England: A new settlement for health and social care*, the King's Fund, 2014, p. 22. http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Commission%20Final%20%20interactive.pdf