

SOLIDARITY AND CARE IN THE UNITED KINGDOM

1. INTRODUCTION

If the Welfare State was born in Britain in the 1940's to widespread if not universal acclaim, it enjoys a less certain position in the political economy fifty years later. Despite the onslaught of 18 years of Conservative government dominated by Thatcherite principles, which vigorously promoted individualism, and at times denied the very existence of 'society', it remains largely intact. Now, like other welfare states it has to accommodate the impact of multinational companies operating in a global economy in a way, which Esping Andersen suggests, undermines distinctive national welfare arrangements (Esping Andersen, 1996). Globalisation demands open systems which allow capital to flow in and out of nation states and in turn places pressures on levels of spending on social provision when economic performance slips. Yet national and cultural systems, values and practices remain visibly present.

The fluidity of international economic activities and the volatility caused by paradigm shifts in technological innovation can rapidly bring about significant positive and negative shifts in employment and market valuations. Recent developments in the microchip industry, decimating the price worldwide, are a pressing example. However the political balances in liberal democracies like those in the UK will not in the present relatively prosperous socio economic climate tolerate serious cuts in health and social care as a result of short term downturns. Margaret Thatcher's government promoted private healthcare, pensions and social services. But the infrastructure of the National Health Service remains, offering quality healthcare free at the point of consumption. Its modes of organisation and accounting have changed to create a market-like tension and the knowledge of treatment costs gives rise to ethical dilemmas in rationing situations.

In the social services sector a more radical change has occurred. Local authority social services departments are no longer the direct providers of services they were in the 1970s. Instead they purchase care from a diversity of suppliers - private for-profit companies; charities; not-for-profit trusts and religious bodies. In the ranking of providers by portion of the market, local authorities have fallen from the top to the bottom. In childcare the big charities predominate. Long term care for the old, so long the province of the state is now increasingly in the hands of the corporate providers plus a cottage industry of small operators both commercial and charitable.

As government drives down the price it is willing to pay for these services more older people are having to pay the full cost (over 30% do already) and almost all a contribution. The lack of resolution about the balance of public and private contributions is straining intergeneration

relations (Johnson, 1995) and the solidarity upon which it rests (Royal Commission on Long Term Care, 1999).

Change and reformation is the new characteristic of Britain's welfare system and the agencies, which comprise it. Bombarded by the business ethic it also struggles to address the challenges of demographic explosion, new treatment regimes and new epidemics like AIDS and Alzheimer's disease. Such dynamic variables are not peculiar to the UK or even Western Europe; they too are global.

A similar transition has taken place in the discourse about the ethical and political underpinning of care systems. In 1950 T H Marshall wrote confidently about the centrality of citizenship and the evils of social class divisions. For him and his left of centre peers, the welfare state was about the democratic overturning of gross inequalities. At the century's end Hills (1998) reports a marked regression in the fight against inequality with companies now presenting reward systems which see some chief executives receiving 100 times the salary of the lowest paid workers. The Trade Union Congress is pursuing a policy of capping top pay to a ratio of four to one, in a -probably vain- attempt to reverse the trend to greater pay differences. So it is not very surprising to discover that 'average incomes grew by about 40% between 1979 and 1994-5' but 'for the poorest tenth average income grew by only 10%'. Hills concludes (a) that the growth in inequality was exceptional by world standards, and (b) 'even with recent falls, overall income inequality was greater in the mid 1990's than in the forty years from the late 1940's' (Hills, 1998).

Thus the ethical substructure of our welfare system has encountered a new mix of practicalities and assessments of the moral economy. Later, we attempt to reflect the debate, which was sponsored by the 50th anniversary of the NHS. But before addressing the current place of solidarity in health care social services and social security as well as within government policy, it is necessary to consider the prior question about solidarity as a public value.

'Solidarity' is an unfamiliar term in the United Kingdom. 'Communitarianism' or 'community responsibility' are more commonly used to describe a sense of public responsibility for the welfare of the community, especially its vulnerable members. Equally people may regard these terms as part of a socialist or social democratic philosophy, though not necessarily in a political sense.

Solidarity raises issues that have roots in the strong empiricism of ethical and social philosophy. In the Scottish enlightenment of the 18th Century, 'common sense' schools associated with Hutcheson, the economic theories of Adam Smith and Hume's radical empiricism, contributed to a social philosophy which saw care for others based on enlightened self-interest or on a natural propensity towards benevolence. However, in England, John Locke sought to base social and political rights on an empirical rather than a metaphysical or theological foundation. Though

potentially revolutionary, British eighteenth century political philosophy was quietly corrosive of traditional institutions, seeking to replace old social hierarchies with a democratic social contract. A contractual approach to social obligations, based at least in part on enlightened self-interest has been typical of the British approach to the obligations of social care.

The nineteenth century industrial revolution initiated profound social changes and the Utilitarianism of Jeremy Bentham and John Stuart Mill, the 'greatest happiness of the greatest number' matched a growing demand to share the rewards of capitalism and to ameliorate its destructive consequences. Major social reforms of the century in education, penal policy, public health and political representation are mostly based on the egalitarian calculations suggested by Bentham or the passionate liberalism of Mill appealing to core values such as knowledge and health, which enhance happiness. Common sense demonstrated why society should be more caring of its vulnerable members. Chadwick pointed out that industry could not prosper if the labouring force was decimated by ill health; it became a matter of expediency to clean up the cities and improve the housing of the poor. There was no appeal beyond this pragmatism to a sense of social obligation, or some universal right to a minimum standard.

British social and political philosophy has always tended to appeal to 'common sense' perceptions of what people need and what society should provide but the claim to empiricism conceals implicit moral values. Does 'common sense' mean an equitable distribution of social resources according to relative need, or does it mean maximising the interests of the majority? A broader question is whether the dominant social value is that of a supportive and caring society or an economically successful one.

The welfare state emerged in post-war Britain based on an analysis of the inadequacy of a voluntary system of charity to meet social need and provide for basic and universal human rights. To this end, Beveridge required that the National Health Service ensure 'for every citizen there is available whatever medical treatment he requires in whatever form he requires it' (Beveridge, 1942, par. 427, Part IV). These social reforms go beyond social expediency to meet the obligation of society to care equally for all its members and to pay particular attention to those most in need but solidarity is not a term in use by the architects of the British welfare state. Illness, poverty and unemployment are seen as obstacles to attaining the inalienable right to freedom and the pursuit of happiness as outlined by the 18th century philosophers. The welfare state's pooling of material resources is a means to removing the obstacles and helping those in need.

Much has been written about the origins of and the motivations, which fuelled the creation of the British National Health Service (NHS). A state funded and organised system in which doctors worked without submitting bills to those who received their service was both a socialist ideal and the will of the post-war government determined not only to win the war but win the peace. Bevan's conception of the NHS was profoundly influenced by

Beveridge's classic proposals for comprehensive social and financial provision (1944), which have also been seen as visionary and infused with aspirations to social justice.

On balance, the romantic/ethical story has won out over the version, which says it was the inevitable consequence of a desire to centralise power in the hands of government. Two themes seem to dominate, the bold desire to provide universal access to healthcare and the struggle between the Labour government and the medical profession. Michael Foot, (1973) depicts Bevan as a class warrior carrying the banner for what is good and right, a politician fired with evangelical zeal to create a more equal society. Condemning the old system, Bevan wrote 'No society can legitimately call itself civilised if a sick person is denied medical aid because of lack of means, *Heralding the new*, he added:

Society becomes more wholesome, more serene, and spiritually healthier, if it knows its citizens have at the back of their consciousness the knowledge that not only themselves, but all their fellows, have access, when ill, to the best that medical skill can provide (Foot, 1973, p. 103).

Contemporary commentators are less ready to accept either the great man or the great idea theory of history. Rudolf Klein (1989) and others see the architects more as a cumulative body of opinion. He presents the chain of ideas with origins in the 1930's, which, in the light of Keynes work, had largely coalesced by 1939. By the end of the war, a convergence of views on the necessity for some form of national health care had been established and the NHS was 'the inevitable outcome of attempts to deal with a specific situation in the light of an intellectual consensus' (Klein, 1989). Glennerster (1995) too takes a strong line, depicting Beveridge, not as the originator of a major organisational concept based upon a moral economy but as a gatherer of the ideas of others, who popularised them in propitious times. 'Thus 1945 marks merely a staging post, not a new departure in social policy' (Glennerster, 1995). It is a matter of judgement and fashion whether you celebrate the collective process or the ultimate discoverer.

The ethical components of the NHS rationale had huge popular appeal when introduced and they still do have. Most citizens view it as Britain's most valued institution and popular sentiment remains strongly in support of universal access to healthcare, free at the point of need. (as we evidence below). The popularity of the NHS means a potentially unlimited demand for care in face of limited resources. What remains unclear is how deeply the British electorate holds convictions about the moral rightness of the welfare state in general. National Insurance has been strained since its beginning because it could not cope when those excluded from benefits grew in number. It never commanded the same popular loyalty as the NHS.

Nevertheless, legislation for the welfare state 'constitutes some of the most coherent and long-lasting institutional legacies in modern British history'

with 'assumptions about the role of the state that were well understood by contemporaries' (Glennister, 1995, p. 2). For Titmuss it was the measure of an altruistic society. He was convinced 'the social measures that were developed during the war centred round the primary needs of the whole population irrespective of class, creed or military category' and 'that the acceptance of these social disciplines - of obligation as well as rights - ... must influence the aims and content of social policies ... in peace-time as well' (Titmuss, 1958, pp. 82, 85).

There was visionary appeal and the NHS may be seen as a benchmark against which subsequent developments can be weighed. Changes over the last fifty years have called into question the realism of financing the NHS through taxation, the state's commitment to the principle and the nature of popular support. The nineteen eighties saw something of a utilitarian approach with priority given to health measures most likely to benefit the majority. The question of merit also appeared in the public debate on rationing health care (with echoes of the 19th century distinction between the 'deserving' and the 'undeserving' poor in relation to AIDS or smoking related illnesses). The challenge of financing the system to acceptable standards remains. With it stands the question whether changes introduced to accommodate the pressure of costs, have compromised or are threatening to compromise the solidarity epitomised in the NHS of Bevan.

2. CARE SERVICES

2.1 The National Health Service - Costs and Care

A sustained theme throughout the life of the NHS has been expanding demand, increased but constrained budgets and serial organisational change. The list of re-organisations is so lengthy they could not all be mentioned in a chapter of this scope. Suffice it to say that the size, geographical shape, population served and hospital base for the operational level of local health 'District' or 'Area' has been in constant motion since the major upheaval of 1974. This has been in the usually mistaken belief that it would improve performance, cost effectiveness, local accountability, co-terminosity with local government areas or shift the balance between the dominant professions. What no government has seriously attempted to do was break the original principles of universality, public funding and free at the point of consumption.

After fifty years the NHS is recognisably the same institution in three important ways. It is still a national system under direct - if now disseminated - central control. It is still publicly funded. It is still universally free at the point of use for the majority of services. In 1997-98 the total cost of the NHS was £36 billion in England and £42 billion for Britain as a whole (more than £1700 for every household). Ninety four per cent of this money is raised from direct taxation, through income tax or

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