

The government of health care and the politics of patient empowerment: New Labour and the NHS reform agenda in England

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Abstract¹

This article considers the issue of patient empowerment in the context of New Labour’s proposed reforms to the National Health Service (NHS) in England. Through an exploration of some of the key measures in the Government’s White Paper *High Quality Care for All*, the article argues for a conceptualisation of patient empowerment as a political technique of governing. Patient empowerment, it is contended, can no longer be understood solely as a quantitative phenomenon to be balanced within the doctor-patient relationship. Rather, its deployment by the Government as a way of governing health and healthcare more broadly demands that we consider what political functions – including, importantly, it is argued here, managing the problem of the increasing cost of illness and healthcare – patient empowerment may be involved in performing. In order to assist in this enquiry, the paper draws on some of Michel Foucault’s work on the art

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of governing. It is suggested that his understanding of the neo-liberal mode of governing best captures the proposed changes to the NHS and the role patient empowerment plays in their implementation.

Introduction

This article seeks to shed some light on the notion of “patient empowerment”, which features prominently in the UK Labour Government’s proposals for the future development of the National Health Service (NHS) in England (Department of Health 2008) (hereinafter referred to as ‘the Report’). Specifically, it reflects on what the use of this notion can reveal about both the manner in which health and publicly funded healthcare will be governed in England in the future, and the nature of the Government’s broader political objectives instituted in the reforms. The article is therefore an attempt to comprehend how “patient empowerment” is deployed as a political technique of governing in the fields of health and healthcare.

At first sight, it may appear strange to undertake such an analysis. This is so for three reasons. First, should we not simply be rejoicing at this political endorsement of an objective – individual empowerment in the fields of health and healthcare – that many have spent a long time arguing and campaigning for? Does it not pleasingly mark the reversal of what Ivan Illich once described as ‘the expropriation of health’ – that is, the colonisation by medicine and medical professionals of illness and pain, and the concomitant disempowerment of individuals to manage these by themselves (Illich 1990)? In the field of healthcare law, does this recognition of patient empowerment not constitute the realisation of what might be taken to be that subject’s overriding *raison d’être* since its contemporary inception at the end of the 1970s – namely, the pursuit of patient autonomy and the corresponding diminution of professional medical power?¹ In short,

why would one wish, or dare to wish, to engage in a critical analysis of such a self-evidently sound and popular discourse as empowerment? Secondly, and in any case, is there really anything new here in policy terms? Are the current proposals for reform not simply the latest instalment of what is becoming a long line of healthcare policies seeking to render patients the key drivers of the NHS? Amongst others, Janet Newman and Elizabeth Vidler have noted how the themes of empowerment, choice, and responsibility were not invented by the current Labour Government but stretch back to the Thatcher and Major Conservative administrations of the 1980s and 1990s (Newman and Vidler 2006). The titles of the White Papers and other documents they cite – *Working for Patients*, *Caring for People*, and *The Citizen's Charter* – testify to this. Since Labour came to power in 1997, this trend has continued. *The NHS Improvement Plan: Putting People at the Heart of Public Services* and *Choosing Health: Making Healthy Choices Easier* are just two examples of how central patients are today to the Government's vision, and reform, of the NHS. Finally, given the voluminous critical literature that has sought to analyse the nature of patient empowerment (including associated ideas of choice and responsibility) and the citizen generally under New Labour, what more might usefully be added by way of commentary and analysis?²

Answers to these questions are best elucidated through an outline of the contributions this article seeks to make. First, the paper places the proposed NHS reforms within a broader historical and political context than that which exists in the current literature. Thus, rather than viewing the reforms as the latest development in a process that commenced in the 1980s, it is suggested that some of the key themes and political objectives inherent in the Report are remarkably similar to those described by Michel Foucault in his analysis of what he calls 'the politics of health in the eighteenth century'. In particular, it is argued that the most striking resemblance between today's

proposals for the reform of healthcare policy and the political engagement with health in the eighteenth century is the underlying economic rationale for the political concern with health. Unlike much of the literature that has employed Foucault's work on governmentality to make sense of the emphasis on patient empowerment today (and the empowerment of citizens generally), this article does not conceptualise the role played by this notion primarily in moral terms – that is, as a subtle technique through which patients and individuals become responsible for their own health and begin, without state oppression, to act in ways which conform to the types of 'healthy' norms in the minds of those in power.³ Rather, patient empowerment, it is suggested, is better understood as a political technique through which the Government seeks to manage the economics and economy of England's publicly funded healthcare system.

Secondly, and drawing on some of Foucault's later work on neo-liberalism, the article argues that, rather than resembling an 'art of governing' premised on the frugality of government, the reforms contained in the Report are more accurately comprehended as an instance of the active intervention of the state – actively striving to ensure that healthcare, like other areas of social policy, is modelled on market principles. Again, the empowerment of patients is a key technique through which this political objective is implemented. Unlike conventional understandings of neo-liberalism, which posit a shift away from the traditional social protection offered by the welfare state and towards the market, the analysis of the proposed healthcare reforms offered here points to a more complex renegotiation of the social and the economic within social policy.

Finally, and at a more disciplinary level, the article is intended, in part, as a contribution to the field of healthcare law. In contrast to the critical literature that exists on patient empowerment within social policy studies, academic lawyers have only rarely ventured outside the standard bioethical paradigm in order to reflect on the importance placed on the patient today. Wedded to

the ethical principle of respect for patient autonomy and the concomitant discourse of patients' rights, more often than not the emergence of patient empowerment is viewed within healthcare law as an unquestionable good and analysed, and reflected upon, within the narrow context of the doctor-patient relationship. In seeking to bring the insights of social theory to bear on the issue of patient empowerment, this article is intended to contribute to a non-ethical approach to the study of healthcare law.

High Quality Care For All: NHS Next Stage Review Final Report

As its title indicates, the core objective set out in the Report is to establish within the NHS 'high quality care for all'.⁴ The measures are designed to address existing disparities in the quality of care offered by the NHS so that, in future, high standards will exist across England's publicly funded healthcare system. 'Quality' care is defined within the Report as care which is 'clinically effective, personal and safe' and various methods are proposed by which the movement towards the goal of 'high quality care for all' is to be undertaken. The important method for the purpose of this paper is the empowerment of patients.⁵ The relatively recent trend whereby patients have been afforded more rights and control over their health and healthcare in the context of the NHS is to be continued and extended. Specifically, the empowerment of patients is to be furthered through the development of 'greater choice, better information, and more control and influence'. Let us look a little more closely at what the Report envisages by these.

Increased patient choice is a core feature of the Report; so important that a new legal right to choice has been enshrined in the NHS Constitution originally proposed in the Report (Department of Health 2009). While patients can already choose where to receive secondary or hospital-based care, the Report undertakes to extend this in the fields of primary and community

care. Thus, while currently individuals may select which GP practice to register with, the fact that this is sometimes not feasible in certain areas (owing, for example, to closed patient lists) means that more measures must be taken to ensure greater choice exists in practice. As well as being a means to empower patients, increased patient choice is also designed to perform another function – what may be described as the allocation of financial resources within the NHS. Thus, as regards secondary care, the Report states that: ‘Choice gives patients the power they need in the system, as NHS resources follow patients in the choices they make.’ (Department of Health 2008: 38) Similarly, in future, individuals’ choices of GP practice will determine the funding such practices receive. The current system, whereby GP practices are funded through guaranteed income payments, will be phased out and replaced by ‘fairer rewards for practices that provide responsive services and attract more patients.’ (Department of Health 2008: 39) It will be the requirements of the local population, expressed through its choices of practices, which will control how resources are allocated.

The empowerment of patients also depends on the provision of sound information. It is only when in possession of this that it is possible for choices to be informed ones. The Government’s proposal here is to make available to patients information on the quality of care provided across the NHS. This will include information regarding other patients’ ‘experiences such as satisfaction, dignity and respect and ... measures of outcomes that include patients’ views on the success of treatments’ (Department of Health 2008: 39). The existing NHS Choices website will also provide a wider range of information for patients than is currently available, including details regarding ‘the range of services offered by GP practices, their opening times, the views of local patients, and their performance against key quality indicators.’ (Department of Health 2008: 39-40)

As well as through greater choice and better information, patients are to be empowered by increasing the control they exert over their own health and healthcare. The idea here is to move away from a culture in which patients depend solely on the NHS to satisfy their care needs and towards one defined by an ethos of self-help, where patients ‘use their personal knowledge, time and energy for solving their own health problems’. The role of the NHS in this scenario will be confined to the provision of such information and support as to enable patients to care for themselves. In relation to so-called ‘lifestyle diseases’ such as obesity and alcohol related illnesses, there ought to be a recognition that the NHS cannot provide solutions for these. Rather, the onus is to shift to individuals to ensure they remain free from such diseases by making responsible decisions about their lifestyle. Patients, therefore, are to be empowered by taking control of their health and healthcare and seeking out their own solutions to their illnesses.

The final way in which the Report seeks to enhance patient empowerment is through extending the influence that patients exercise over the direction of NHS resources. One aspect of this has already been mentioned above in the context of greater patient choice – ie that resources will follow patients’ choices of healthcare provider. But the allocation of NHS resources will, in future and to a degree, also depend on patients’ experiences and impressions of the success of their treatment (so-called PROMs – patient-reported outcome measures). This is because these features are to be key criteria in the measurement of the ‘quality of care’ provided by hospitals.⁶ The higher the level of quality of care in a hospital, the greater the share of NHS resources it will receive. Patients will therefore play a much more important role in determining the allocation of NHS resources. Another way in which the proposals seek to give patients greater control over resources is through ‘personal health budgets’. These are designed especially for those with chronic, stable conditions and will afford greater control to patients ‘over the services they

receive and the providers from which they receive services’ (Department of Health 2008: 42, reference omitted).

Patient empowerment therefore constitutes a core method by which the Government proposes to achieve its objective of ‘high quality care for all’. The purpose of the next section is to offer some reflections on the foregoing provisions on patient empowerment with a view to both shedding light on their implications and thinking through the possible reasons why patient empowerment has been selected as a core feature of the proposed reforms.

Patient Empowerment and the Responsibility to Choose

There can be little doubt that the culture of consumerism has heavily influenced the Government’s focus on patient empowerment that appears in the Report. The discourses of choice, control and influence are central to consumerism and the Government has sought to ensure that the proposed changes to the NHS reflect broader societal shifts.⁷ This can be illustrated clearly in Chapter 2 of the Report – ‘Changes in Healthcare and Society’ – where the proposed reforms are set against a backdrop of developments in both healthcare and the wider society. One of these developments is the higher expectations that different generations will have of healthcare providers. For instance, today’s younger generations:

are influenced by new technologies that provide unprecedented levels of control, personalisation and connection. [These generations] expect not just services that are there when they need them, and treat them how they want them to, but that they can influence and shape for themselves. Better still, they will want services that ‘instinctively’ respond to them using the sophisticated marketing techniques used by other sectors [the Report cites the personal recommendations given by Amazon to its customers]. This is more than just a challenge for healthcare, but for our whole model of how we think about *health* (Department of Health 2008: 26. Original emphasis).

In other words, people today not only expect to be in control of services and to dictate how they ought to meet their needs; they also assume that the companies providing services will anticipate, and inform them of, their specific needs and requirements based on the previous choices they

have made (hence the frequent reference in the Report to the need for a more ‘personalised NHS’). Similarly, and as noted in the previous section, patient choice plays a key role in the proposed reforms. One way, then, of explaining the focus on patient empowerment in the Report would be, as the Government has done, to see it as reflecting the need to align the NHS with the 21st century’s dominant culture – consumerism. I shall return to this below, for it constitutes a necessary but insufficient explanation for the appearance of patient empowerment in the Report. For now, I want to identify an important implication of the stress laid on patient empowerment in the proposed reforms.

Rather than being emancipatory, as one might expect, patient empowerment would seem to entail placing a number of demands or responsibilities upon patients. For instance, the proper functioning of the ‘NHS Choices’ website and, crucially, the measurement of the quality of care within the NHS generally, will depend on patients providing feedback both on their perception of the success of their treatment and the quality of their experiences. Indeed, the centrality of patient feedback to the success of the reforms is evident in its being raised to the status within the NHS Constitution not of a patient right, but of a patient *responsibility* (‘You should give feedback – both positive and negative – about the treatment and care you have received ...’). The new legal right to choose would only appear to be meaningful if there is sufficient information (including that provided by patients) available upon which to base one’s decision. There is also a clear emphasis on patients and individuals assuming responsibility for the management of their own health and healthcare, whether that be tending to themselves at home or, more generally, making responsible choices about what they consume. While presented as a matter of increased control and choice (in that individuals are to be empowered to make their own choices through the provision of information by healthcare staff), it is clear that, in future, the onus will be on

individuals and patients ‘to use their personal knowledge, time and energy for solving their own health problems.’ Again, the general tenor of this point is captured in the following responsibility of patients and the public set out in the NHS Constitution: ‘You should recognise that you can make a significant contribution to your own, and your family’s, good health and well-being, and take some personal responsibility for it.’⁸

It is suggested that a further responsibility can be discerned from the proposals in the Report. This is what might be described as a general responsibility on the part of patients within the future NHS to act as consumers. This ‘responsibility’ does not relate to any specific aspect of health or healthcare – such as taking more care of your health by cutting down on the amount of alcohol you drink or curbing the frequency with which you indulge in the consumption of fatty food. Rather, the responsibility here is to the very nature or rationale of the system – consumerism – which these reforms seek to apply to the NHS in future. In other words, patients, and the public generally, have *a responsibility to choose* within the context of England’s publicly funded healthcare system;⁹ a responsibility to rate their service providers and judge the success of their treatment, even though it is highly unlikely that they will possess the relevant expertise and knowledge which would enable them to do so; a responsibility to provide feedback in order that future patients can make informed choices as to where to go for medical treatment. In other words, it does not, for example, matter so much how you exercise your choice – whether you elect to be treated at hospital X rather than at hospital Y is really neither here nor there; the crucial point is that you *make a choice* between service providers. The responsibility is to comply with the system’s overarching rationale, rather than to ensure that specific kinds of choices are made. Consequently, the only choice patients would seem not to have the freedom to exercise in the NHS of the future is one that would reject a system which operates on the basis of

choice.¹⁰ Assuming that patients have such a general responsibility to act as consumers in the context of the NHS (including a responsibility to choose), it is possible to ask why this is the case. That is, why should patients act as consumers within the NHS – giving feedback, choosing amongst service providers etc?

As noted above, one answer to this question would be to assert, as the Government does in its Report, that the NHS simply has to move with the times. Currently it is out of sync with the manner in which the public routinely engage with other services and the consequent heightened expectations that flow from this. Put shortly, the public act as consumers in other areas of life, so why should the NHS be any different? Another explanation might be that, after what some have argued has been years of patient subjection to the medical juggernaut – that is, patients having to submit to the advice and decisions of doctors rather than being free to make their own choices – the tide has finally turned in favour of those seeking medical treatment. After decades of argument and campaigning, patient autonomy and choice have finally triumphed and now patients must exercise their hard won rights. There can be little doubt that these are explanations offered for the Government's decision to embed the consumer model within the NHS. They do not, however, tell the whole story. Importantly, they fail to note how the responsibility to act as a consumer within the NHS is related to the furtherance of what can be identified as a core political objective underlying the proposed reforms – the management of cost.

It is suggested that one of the central political concerns here is a fiscal one. The problem is how to address an issue that has recently come to re-occupy the forefront of political debate – that of the rising cost of public services and how best to manage this.¹¹ These services, the argument goes, are just too expensive today, and, owing to an ageing population, cannot be sustained at their current levels in the future through general taxation. This concern with cost can be seen at

various points throughout the Report. The following are just a few examples: ‘For the NHS *to be sustainable* in the 21st century it needs to focus on improving health as well as treating sickness.’ (Department of Health 2008: 4. Emphasis added.); ‘[The need to ensure] that clinically and *cost effective* innovation in medicines and medical technologies is adopted.’ (Department of Health 2008: 7. Emphasis added.); ‘Increasing expectations, an ageing population, a rise in lifestyle disease and the cost of new treatments will all impose *greater costs*.’ (Department of Health 2008: 31. Emphasis added.) It is this *problem of cost* that, it is suggested here, constitutes a core object of government in the field of publicly funded healthcare, and patient empowerment is the technique by which it is governed. By deepening the role of choice of provider within the NHS – with resources following patients’ choices – and making the measurement of ‘quality of care’ much more dependent on patients’ views about the success of their treatment and quality of experience, the Government renders the decisions and opinions of patients the means of managing costs.¹² Assuming that particular hospitals and GP practices are more popular than others, the viability of those that do not attract many patients would seem to be placed in doubt. Would they, and the staff running them, continue to operate? While this is not a question that is answered in the Report, one might envisage a worst case scenario where the lack of a sufficient number of patients choosing to be treated in a hospital or GP practice, and / or poor feedback on how successful patients believe their treatment to have been, would threaten to put such a hospital or GP practice out of business. Clearly, such an event would provide immediate savings in respect of costs (eg the opportunity created to dispose of the buildings¹³).¹⁴ Similarly, the shift to individuals taking more control over the management of their health and healthcare, and thereby reducing their dependence on the NHS, has the potential advantage of lessening the cost of publicly funded healthcare.¹⁵

Patient empowerment therefore provides a useful means by which to govern an NHS concerned with the problem of cost. But as well as being a technique through which to pursue the political objective of fiscal prudence, patient empowerment also performs three other crucial political functions. First, it offers the Government the possibility of deflecting potential criticism of its management of public expenditure on healthcare by passing responsibility for this onto patients and the choices they have made. Rather than obviously being a product of government policy, this management can be explained away by the operation of market forces. The people are deciding about the viability of healthcare services through their choices, and not the Government. Of course, while this does not remove the fact that the system which creates the possibility of this explanation is the direct outcome of a *political* choice, the emphasis on patient empowerment and *individual* choice nonetheless conveniently obscures this. Secondly, patient empowerment acts as an indirect legitimating device for the Government's ongoing transformation of the NHS into a service based on the market model and the pursuit of fiscal prudence. It functions as a way in which consent for this political transformation can be secured, albeit implicitly. This is because the core ideals underlying patient empowerment, including freedom of choice, individual control, and human dignity resonate with some of what David Harvey has called our fundamental 'intuitions and instincts'. In the following passage, Harvey describes how important it is for those in power, when attempting to institute a model of thought or practice, to appeal to seductive and intuitive ideals:

For any way of thought to become dominant, a conceptual apparatus has to be advanced that appeals to our intuitions and instincts, to our values and our desires, as well as to the possibilities inherent in the social world we inhabit. If successful, this conceptual apparatus becomes so embedded in common sense as to be taken for granted and not open to question. The founding figures of neoliberal thought took political ideals of human dignity and individual freedom as fundamental, as 'the central values of civilization'. In so doing they chose wisely, for these are indeed compelling and seductive ideals. These values, they held, were threatened ... by all forms of state intervention that substituted collective judgements for those of individuals free to choose (Harvey 2005: 5).

Similarly in relation to the proposed reforms on healthcare contained in the Report, the Government ‘chooses wisely’ when it selects patient empowerment, and its associated values of individual choice and human dignity¹⁶, as its conceptual apparatus – not only because these are intuitively attractive per se; but because this attractiveness heightens the likelihood of a smooth transition to a publicly funded healthcare service based on the market model. Patient empowerment has a greater chance of garnering consensus around the proposed future direction of the NHS, and therefore of lending legitimacy to the Government’s reform programme. This consensus is not overt but silently flows from the instant appeal and taken for granted nature of the conceptual apparatus underpinning the reforms.

Finally, the deployment of patient empowerment within the NHS contributes to the more general desire to ensure that political power becomes more closely entwined with market principles. This is true in two senses. First, and as will be discussed more fully later in the paper, social policy today increasingly functions as a way of promoting and embedding the market. Its underlying rationale is shifting from the amelioration of the social costs of the market to putting in place the means of fostering both competition and the belief that the market itself offers the best sources through which social needs can be met. Secondly, and as highlighted earlier, there is the increasing uptake of market discourse and the application of marketing techniques in the political field. This economisation of politics has important ideological effects as individuals begin to treat public institutions in exactly the same way as they do other services – that is, as consumers.

The discourse of patient empowerment contained in the Report is therefore important in a number of *political* ways. It is a useful means by which to pursue a variety of political objectives – especially the management of cost and the extension of the market model both within the NHS and as a means of healthcare provision outside of it. It also increases greatly the chances of

obtaining public support for these objectives. But if all this is so, how might one make sense of the types of developments described so far? Are there any resources to hand that might help to place the proposed reforms, and the relations this article has identified as inherent within them – among health, politics, economic considerations, patient empowerment as a technique of governing – within a broader sociological, political and historical framework? It is suggested that some of Michel Foucault’s work can assist in this regard, and it is to a consideration of this that I now turn.

Foucault on Government and the Politics of Health

It will be useful, in the first instance, to turn to an essay – ‘The Politics of Health in the Eighteenth Century’ (Foucault 2000) – in which Foucault directly addresses the relationship between government and the politics of health.

According to Foucault, one of the defining characteristics of the eighteenth century was the emergence of ‘a politics of health, the consideration of disease as a political and economic problem for social collectivities which they must seek to resolve as a matter of overall policy’ (Foucault 2000: 91). This ‘noso-politics’, as he calls it, was not driven by an agenda set solely by the state – if, by that, one means some sovereign, unitary body; rather, it was the product and concern of a variety of organisations throughout society. And its objective was ‘the health of all as a priority for all, the state of health of a population as a general objective of policy.’ (Foucault 2000: 92) This striving for health found its roots in utilitarian concerns. The problem was how to augment the health of the population so that it would become more useful, specifically in an economic sense – through, for instance, maintaining a healthy workforce. This had a number of effects, such as the greater importance of the family as a site where the production and

management of healthy individuals could be undertaken. Moreover, not only did the family provide a useful locus germane to the inculcation of a disposition towards good health; it also lowered the cost of doing so, for it kept people out of hospitals and placed the financial burden of maintaining patients on the family rather than on the state. It also meant that the onus of treating patients medically could be transferred to the family, for, after the provision of some medical advice, family members would be in a position to look after the patient on a constant basis. Hospitals themselves were uneconomic in the further sense of merely sustaining the survival of paupers and their illnesses, rather than being institutions contributing to the overall increase in the level of health. The perpetuation of illness through the unavoidable circulation of germs within the enclosed space of the hospital, and their transmission to the outside world on discharge, rendered hospitals ‘dead weight[s] on the economy’.

What is clear from Foucault’s portrayal of the politics of health in the eighteenth century is how squarely it rests on a concern with economy. This is so in a number of senses. First, a healthy population is crucial to providing the labour necessary for the production upon which the success of the economy depends. Secondly, the manner in which the objective of a healthy population is pursued shows a concern for the most cost-effective methods to be deployed. Finally, and related to this, Foucault’s description of the integral role of the family in improving the health of the population is economic not only in saving the state money, but in the original sense of the word. Deriving from the Greek *oikos*, economy originally referred to the management of a household. As such, Foucault’s observation that, in the eighteenth century, ‘each family will be enabled to function as a small, temporary, individual, and inexpensive hospital’ – ‘a domestic form of “hospitalization”’ – points to the economic basis of the politics of health in the eighteenth century. This eighteenth century concern with economy in the field of social policy extended

beyond health. Referring to the question of the reform of penal law at the end of the eighteenth century, Foucault notes that reformers, especially Jeremy Bentham, approached the question as an economic one. The existing problems were characterised as problems of cost:

[H]ow much does it cost a country, or at any rate a town, to have thieves running free? There is the problem of the cost of judicial practice itself and of the judicial institution in the way that it operates. And there is criticism of the ineffectiveness of the system of punishment ... What the reformers sought by filtering the whole of penal practice through a calculation of utility was precisely a penal system with the lowest possible cost ... (Foucault 2008: 248)

What is remarkable about Foucault's analysis is how similar some of the features and themes of the politics of health in the eighteenth century that he describes are to those contained in the Government's proposed NHS reforms. The concern with the improvement of the health not only of those who are currently ill, but of the population generally; the domesticisation of healthcare and the corresponding shift in the role of the NHS from curer to advisor and supporter¹⁷; the central role to be played by a variety of societal institutions and organisations in the promotion of health (in the eighteenth century these included religious groups and charitable associations; today, the Government, in its Report, points to the role that employers, and private and third sector organisations can play in improving and maintaining levels of health¹⁸); and, crucially, the underlying economic rationale for these proposed developments. Adapted to the field of healthcare, for example, similar types of questions to those posed by Bentham would not look out of place in today's proposed NHS reforms: How much does obesity, excessive alcohol consumption, and smoking cost the country? What steps can be taken to improve the effectiveness of the NHS? What is the best means by which to ensure the sustainability of the NHS in the future? This resemblance between the politics of health in the eighteenth and twenty-first centuries suggests that the foregoing features of the proposed NHS reforms are not novel; rather, they indicate a reversion to a historical settlement between politics and health. If this is true, then what might account for this similarity?

It is suggested that an explanation can be sought in the nature of governing. We can return to Foucault for this. In his study of what he calls ‘the art of governing’, Foucault traces the historical development of ‘the rationalization of governmental practice’ (Foucault 2008). From the middle of the eighteenth century, a principle of governmental practice emerges that revolves around the question of ‘how not to govern too much’. The core problem in the realm of governing is how to avoid excessive government and to govern frugally. The State is not to intervene directly in the market or civil society by imposing specific rules and prohibitions by which individual behaviour is to be judged, but to govern at a distance by functioning as a facilitator or enabler of good conduct. This shifts attention away from the state and onto other actors and institutions and their roles in the exercise of power over individuals’ behaviour. The problem here, Foucault says, was one that was central to liberalism – that is, of how to place limits on the state and to create a space of freedom in which actors can be left alone to pursue their affairs. As noted, the NHS reforms contain elements that may be thought to resemble this type of governmental practice, especially as regards the devolvement of power to individuals and families to control or manage their own health and healthcare and the attempt to increase the role played by non-state actors in the field of healthcare. It is suggested, however, that liberalism cannot provide the best explanation of the proposed reforms. For what may at first appear as an instance of state retrenchment in the field of healthcare – the cutting of costs, the transfer of authority for maintaining health to individuals and their families, the emphasis on patient choice – can, rather, be interpreted as the state’s active intervention with the objective of tying healthcare delivery, both within and outside of the NHS, to the market and its principles. Thus, the focus on patient empowerment in the reforms is not best read as a concession of state power but as an example of its exercise – patient empowerment is the technique through which the state

actively implements a change in the nature of its social policy on healthcare by founding this on the market and the promotion of the market and its principles. As Karl Polanyi reminds us, the shift to a society structured on the principles of market economy was not some kind of natural event that occurred spontaneously; rather it was the result of a deliberate policy: ‘[L]aissez-faire economy was the product of deliberate state action ... *Laissez-faire* was planned; planning was not.’ (Polanyi 2001: 147)

Understanding the reforms in this way forces us to revisit and rethink some of the core founding principles of the NHS and, given the steady marketisation of other areas within the field of social policy, of the welfare state generally. Here, I simply want to mention one such principle – solidarity. The thrust of the meaning of solidarity in the context of the UK’s welfare state can be illustrated in the following passage from William Beveridge’s 1942 Report on social insurance:

The proposals of the Report mark another step forward to the development of State insurance as a new type of human institution, differing both from the former methods of preventing or alleviating distress and from voluntary insurance. The term “social insurance” to describe this institution implies both that it is compulsory and that men stand together with their fellows. The term implies a pooling of risks except so far as separation of risks serves a social purpose (Beveridge 1942: 13).

Here, solidarity denotes both a national form of insurance based on the pooling of risks and an idea of community amongst citizens in which those who, for whatever reason, require assistance are entitled to it on the basis of need alone. In times of hardship, ‘men stand together with their fellows’.

In charting the shift from a Keynesian to post-Keynesian world, many academic commentators have argued that one of the symptoms of this transformation has been a crisis of solidarity. Changes in the socio-economic structure of Western societies, such as deregulation of the labour market, have removed the bases upon which the solidarity of the post-WWII years rested.¹⁹ Related to the context of the current paper, John Harrington has argued that one of the

consequences of globalisation, with its turn to the marketisation of healthcare services, has been ‘the weakening of solidaristic national health systems.’ (Harrington 2007) There has been a shift away from ‘the more traditional welfarist paternalism of the nation state’ to ‘global economic [neoliberal] liberalisation’. For Zygmunt Bauman, ‘liquid modernity’ ushers in ‘an individualized, privatized version of modernity, with the burden of pattern-weaving and the responsibility for failure falling primarily on the individuals’ shoulders. It is the patterns of dependency whose turn to be liquefied has now come.’ (Bauman 2000: 7-8)

Of course, the talk of crises of solidarity and the dissolution of traditional modes of dependency capture some key consequences of various social and economic changes over the last 40 years. But this does not mean that the notions of solidarity and dependency lack any purchase as ways of comprehending the types of reforms contained in the Report on the future of the NHS. On the contrary, it could be argued that they are very useful for this purpose. Thus, while there is a clear theme running through the reforms of a shift away from a culture of dependency on the NHS to cure illness, *dependency on the market* would appear to be taking its place. As noted above, patients, and individuals generally, are increasingly ‘to use their personal knowledge, time and energy for solving their own health problems’. But as well as patients, the reforms demonstrate the extent to which the Government itself intends to depend on the market as a way of structuring and organising the NHS and the manner in which it operates. Similarly, while the ‘traditional welfarist paternalism of the nation state’ may, as Harrington notes, be on the decline, should this render all talk of solidarity in the new settlement irrelevant? Arguably, welfare paternalism and the solidarity expressed in Beveridge’s exhortation ‘that men stand together with their fellows’ are alive and well within the reformed NHS; it is just that now, these are becoming increasingly relevant as ways of describing the Government’s embrace of the market and

privatisation within healthcare and other spheres of social policy. The Private Finance Initiative and the growing involvement of private providers in the delivery of both private and public healthcare can be read as instances of *corporate* welfare and as solidarity with the interests of *business*. While Beveridge's "social insurance" system continues to exist today, the public money that underpins it increasingly flows in the direction of private actors and, hence, supports the pursuit of profit. Consequently, the notion of solidarity still captures a core aspect of the contemporary welfare state's engagement with healthcare. We need, however, to reassess the nature of the types of fellows with which today's men (and women) stand together.

The NHS reforms are not, therefore, to be best understood as the simultaneous disempowerment of the state and empowerment of the patient. The State does not divest itself of power; rather it *uses* the idea of patient empowerment as a technique through which to establish the market as a mode of organising both the internal workings of the NHS and the manner in which people should come to think of managing health and illness. In terms of governing, then, and despite its superficial resemblance, this is unlike liberalism, with its concern for how not to govern too much. In order to think through the type of governing this suggested interpretation of the reforms resembles, we can return to Foucault and his analysis of neo-liberalism (Foucault 2008).

Foucault argues that the governmental rationality of the twentieth century is neo-liberalism. In his view, the 'problem' of neo-liberalism is 'how the overall exercise of political power can be modelled on the principles of market economy'. The challenge here, therefore, is how to base the art of governing on market principles. The aim is to have government intervene in society in such a way that it becomes infused with, and regulated by, market principles such as competition and, one might add, choice. This has consequences for the nature of social policy. One of these is that the rationale for social policy undergoes a shift from one that seeks to compensate for the

undesirable effects of the operation of the market to one defined by market principles. The objective is to ensure a level of economic growth is created that will provide individuals with sufficient income to allow them to purchase their own insurance against social risks, rather than this being provided collectively by the state. In one sense, then, the result is a movement away from “collective” social policies and towards “individual” ones, whereby insurance against risks becomes the economic responsibility of individuals rather than of society. Individuals must take measures to care for themselves; they must, as Foucault puts it, become enterprising and enterprises. In short, social policy, and its delivery, becomes marketised and thus concerned with ‘nullify[ing] the possible anti-competitive mechanisms of society [as opposed to ‘the anti-social effects of competition’]’ (Foucault 2008: 160). As Jacques Donzelot has commented, the goal of social policy here is to ‘[sustain] the logic of competition’ (Donzelot 2008). In another sense, though, and as argued above, the “collective” nature of social policy persists. On the one hand, this is expressed through the Report’s emphasis on the continuing importance of one of the founding principles of the NHS – assuming there is a clinical need, healthcare will be free of charge. Equally, though, and on the basis of the Report’s proposed reforms discussed above, the “collective” nature of social policy in the field of healthcare may simultaneously, and increasingly, be better understood as representing a form of solidarity that benefits the profit margins of private providers of publicly funded healthcare.

Unlike liberalism, it is this neo-liberal government that is better placed to capture the nature of many of the proposed NHS reforms described above. The thrust of the proposals is to embed competition as the organising principle of England’s publicly funded healthcare system. They are designed to rid the NHS of its traditional anti-competitive nature and to move away from its traditional function of, as Donzelot puts it, ‘countering the economic’. This is as true outside the

NHS as it is within it. For the exhortation to patients, and individuals generally, to lead healthier lives is meant not only to prevent ill health arising in the first place, and thus the need to seek assistance through the NHS (thereby helping to cut costs); it can also be thought to promote and sustain the market generally by ensuring that people are healthy enough to remain competitive – competition being the essence of neoliberal markets. In the context of healthcare, patient empowerment, and its constitutive features as set out in the Report (and outlined earlier) – increased patient choice, the provision of sound information, increased patient control over their own health and healthcare, and extending the influence patients exercise over the direction of NHS resources – are the vehicles through which the Government’s objective of using social policy to promote and establish competitive markets is realised.

Conclusion

At the beginning of this article it was noted how the realisation of patient empowerment had been argued for by those who accused medicine and medical professionals of having colonised illness and pain and thus removed it from the domain of individual management. The problem, in effect, was that individuals’ autonomy in the field of healthcare had been usurped by the medical profession to such an extent that the former had become very much dependent on the latter. Doctors had too much unjustified power and this needed to be reduced by empowering individuals to care for themselves. On the face of it, therefore, the proposed NHS reforms in *High Quality Care for All*, with the notion of patient empowerment at their core, would appear finally to have redressed this imbalance in power. At long last, patients will not dance to the tune of their doctors but will have the power to call the shots in respect of their NHS care and to care for themselves.

Interpreting the role of patient empowerment in this manner – ie as part of a simple battle of, and for, power between two parties – would, however, be to misrepresent its function in the proposed reforms. This is so because the reforms are about much more than the relative balance of power in the doctor-patient relationship; rather, they concern the future nature of the NHS and the principles upon which it will be organised and operate. In other words, any attempt to understand the role of patient empowerment in the Report must necessarily deal with the matter of how this notion is bound up with these broader political issues. In undertaking such an analysis, this article has argued that patient empowerment is to be best thought of as a political technique of governing. It is the medium through which the New Labour Government not only seeks to manage the problem of rising costs, but to entrench the role of the market in the sphere of healthcare. One of the perverse consequences of this is that, with the move to increase levels of self-responsibility for healthcare (described as a means of empowering patients in the Report), patients are forced to trade their traditional dependency on the medical profession, not for emancipation, but for a new type of dependency – one that comes in the form of a reliance on the market. Moreover, this marketisation does not involve the State’s withdrawal in favour of the market, but represents a more complex arrangement whereby social policy is actively modelled on market principles and, thereby, works in favour of, rather than against, the market.

NOTES

¹ For the argument that patients need to be empowered, see, for example, Kennedy 1988, McLean 1999, and Sheldon 1997.

² As well as Newman and Vidler 2006, see, for example, Petersen and Luton 1996 and Shaw and Aldridge 2003. On the nature of the citizen under New Labour, see Clarke 2005.

³ For an example of this type of analysis, see Petersen and Lupton 1996. Petersen and Lupton equate what they call ‘the new public health’ – which includes the steady shift to the individualisation of responsibility for health and healthcare – to a ‘new morality system’, the purpose of which is to establish a set of ‘moral tenets’ resting on a variety of oppositions, including healthy / diseased and self / other. Their understanding of the ‘new public health’ is inextricably bound up with the moral, subtly prescriptive nature of transformations in the social policy related to health and healthcare.

⁴ The Report builds on previous Government white papers which set out visions for the modernisation of the NHS and healthcare. See, especially, Department of Health 2004a and Department of Health 2004b.

⁵ The other methods are: helping people to stay healthy; providing the most effective treatments; and, keeping patients as safe as possible. The first two of these are also of relevance to the discussion in this article.

⁶ In this regard, see Stratton 2009, who reports that the UK Health Secretary may apply criteria such as the following as a means of determining how NHS funds are distributed: ‘the manner of hospital receptionists; the ease with which patients can use clean toilets; the quality of food; and the cleanliness and attractiveness of wards ... Presently, hospital tariffs are based only on the success of operations.’

⁷ As Zygmunt Bauman has noted: ‘Choice is the consumer society’s meta-value, the value with which to evaluate and rank all other values.’ Bauman 2005: 58.

⁸ This type of responsibility is emblematic of what Peterson and Lupton call ‘the ‘healthy’ citizen’. See Peterson and Lupton 1996: Ch. 3.

⁹ Davies and Elwyn have raised concerns about the effects of what they call “mandatory patient ‘autonomy’” – that is, obliging patients to participate in healthcare decision making, including choosing from a range of healthcare providers and treatment options. See Davies and Elwyn 2008.

¹⁰ While the context is different, this brings to mind David Harvey’s identification of one of the contradictions of neoliberalism: ‘A contradiction arises between a seductive but alienating possessive individualism on the one hand and the desire for a meaningful collective life on the other. While individuals are supposedly free to choose, they are not supposed to choose strong collective institutions ... as opposed to weak voluntary associations. They most certainly should not choose to associate to create political parties with the aim of forcing the state to intervene in or eliminate the market.’ Harvey 2005: 69.

¹¹ As well as healthcare, this issue can, for example, be witnessed in the area of pension provision for those working in the public sector – specifically, the debate surrounding the cost of sustaining final salary pension schemes for public sector employees. See Blackburn 2002. As Seumas Milne has noted, at a time when the consequences of financial meltdown are all too apparent, the reappearance of the issue of public expenditure reduction at the heart of political debate has succeeded in shifting the focus of analysis away from the source of these consequences – the free market model. See Milne 2009. John Clarke has described the theme of the unaffordability of social provision within social policies as ‘fiscalizing the social’. See Clarke 2007.

¹² As John Harrington notes, choice also performs other functions within the NHS: ‘The ‘choice agenda’ is not simply focussed on the behaviour of patients. Along with explicit clinical governance and transparent pricing, patient choice can be an important means of disciplining medical labour. Moreover, it gives a further impetus to privatisation.’ Harrington 2009: 395. This ‘disciplining [of] medical labour’ might also be thought to derive from patient feedback via sources outside of the NHS. For instance, an article in the Observer newspaper told of a new website called *iwantgreatcare.com* which offers patients the opportunity ‘to rate and review every medic who has treated them.’ Campbell 2008.

¹³ Assuming, that is, that they have not been built as part of the Private Finance Initiative. In that case, the Government would be contractually bound to pay off the rent remaining on the outstanding lease.

¹⁴ It is worth noting that this concern with cost is only one indicator of a more general shift to what may be described as the economisation of the discourse deployed in relation to the NHS within the Report. See, for example, the proposal that: ‘All registered healthcare providers working for, or on behalf of, the NHS will be required by law to publish ‘*Quality Accounts*’ just as they publish financial accounts.’ (Department of Health 2008: 5. Emphasis added). For further discussion of this ‘economisation’ in the field of healthcare, see Blomgren and Sundén 2008. This phenomenon can also be witnessed in other areas of social policy. For similar developments in the field of criminal justice, see Garland 2001: 116-17 & 188-9.

¹⁵ While not mentioned in the Report, the logical way of extending and embedding this ethos of self-care would be to encourage individuals to purchase private healthcare insurance.

¹⁶ The NHS Constitution enshrines ‘the right to be treated with dignity and respect, in accordance with your human rights’.

¹⁷ This feature finds its practical expression, for example, in the form of the Expert Patient Initiative, whereby patients are trained how to manage their illnesses (especially chronic ones) and as a result take greater control of their own treatment. While this policy idea is present in the Report, it has a longer history. See, for instance, Labour’s discussion of the Expert Patient Programme in Department of Health 2004a. For an analysis of the Expert Patient Initiative that draws on Foucault’s work on pastoral power, see Wilson 2001.

¹⁸ The Coalition for Better Health, for instance, will take the form of voluntary agreements between the Government, private and third sector organizations, setting out measures to tackle prominent public health problems – initially, obesity. The Reduce Your Risk campaign is intended to heighten awareness of vascular risk assessment.

¹⁹ See, for example, Delanty 2008.

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