

The impact of Thatcherism on health and wellbeing in Britain

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Abstract

Margaret Thatcher (1925-2013) was UK prime minister from 1979-1990. Her informal transatlantic alliance with US president Reagan from 1981-89 played an important role in the promotion of an international neoliberal policy agenda which remains influential today. Her critique of UK social democracy during the 1970s and her adoption of key neoliberal strategies, such as financial deregulation, trade liberalisation and the privatisation of public goods and services, were popularly labelled Thatcherism. In this paper we consider the nature of Thatcherism and its impact on health and wellbeing during her period as prime minister and to a lesser extent, in the years that follow; we focus mainly on Great Britain (England, Scotland and Wales). Thatcher's policies were associated with substantial increases in socioeconomic and health inequalities: these issues were actively marginalised and ignored by her governments. In addition, her public sector reforms applied business principles to the welfare state and prepared the National Health Service for subsequent privatisation.

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...with Thatcherism, she set out to save the soul of the nation and ended up selling it off to the cheapest bidder... People who didn't agree with Mrs. Thatcher were just not 'one of us,' they deserved no empathy, had to be beaten, and Britain for a while found her drama of certainty addictive... Spite came to live in Britain during her time and we became partisan to the point of psychosis... Margaret Thatcher's greatest legacy will be to have made Britain a place more out of love with the idea of tolerance.

- Andrew O'Hagan, *Maggie* (1)

Margaret Thatcher (1925-2013) was UK prime minister from 1979-1990. Her informal transatlantic alliance with US president Reagan from 1981-1989 played an important role in the promotion of an international neoliberal policy agenda which remains influential today. Her critique of UK social democracy during the 1970s and her adoption of key neoliberal strategies, such as financial deregulation, trade liberalisation and the privatisation of public goods and services, were popularly labelled 'Thatcherism'. In this paper we consider the impact of Thatcherism on health and wellbeing during her period as prime minister and to a lesser extent, in the years that follow; we focus mainly on Great Britain (England, Scotland and Wales).

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Introduction: Thatcherism in overview

Thatcherism has had a fundamental and long term impact on public health and health inequalities in Britain due to the way it affected the social determinants of health and made socioeconomic position an ever more important factor in health and wellbeing (2). Thatcherism has been described as an ideological project which set out to radically re-cast the relationship between labour and capital and between the state, society and the individual (3). Thatcherism and the New Right provided a narrative which explained the crisis of British capitalism in the 1970s as a crisis of the welfare state, high wages and low productivity; of the 'undemocratic' power of what in 1984 she called 'the enemy within' – the trade unions (4). This was accompanied by a racialised discourse targeting non-whites and immigrants (5). Thatcherism set out to systematically dismantle the structures of the post-war Keynesian consensus around the social wage, full employment, the corporatist state and the size and role of the public sector. This goal was pursued through the aggressive promotion of the free market alongside the 'hollowing out' of the state (6). Thatcher's political programme included: (i) deregulation of the labour and financial markets (including the 'Big Bang' deregulation of the City of London in 1986); (ii) the privatisation and marketisation of the main utilities (water, gas and electricity) and state enterprises (e.g. British Steel, British Rail and British Airways); (iii) the promotion of home ownership (including the widespread sale of public housing stock under the 'right to buy' scheme); (iv) the curtailing of workers' and trade union rights (e.g. bans on the 'closed shop', obligatory membership ballots before any industrial action, restrictions on the right to picket including a ban on secondary picketing, and

removal of trade union immunity from damages); (v) the promotion of free market ideology in all areas of public life (including health care and the civil service); (vi) significant cuts to the social wage via welfare state retrenchment (e.g. a 7% reduction in state expenditure on social assistance between 1979-89; removal of 16-18 year olds from entitlement; reductions in state pensions; abolition of inflation-link for welfare benefits); (vii) an acceptance of mass unemployment as a price worth paying for the above policies; (viii) large tax cuts for the business sector and the most affluent (e.g. during Thatcher's premiership, the rate of income tax for the top tax bracket was reduced from 83% to 40%) (7, 8).

This paper considers how these and other policy changes shaped the health and wellbeing of the British population and altered the subsequent policy landscape. We first review the political economy of Thatcherism and then outline health-relevant social policy reforms. We consider Thatcher's denial of health inequality as a policy concern, including the rejection of the Black report. We discuss how Thatcher's governments began the application of private sector management principles to one of Britain's most popular socialist creations, the National Health Service (NHS) - and in doing so, paved the way for subsequent NHS privatisation by the governments of Blair, Brown and Cameron (9). Finally, we draw on a range of data to summarise the impacts of Thatcher's policy reforms on social determinants of health and health inequalities. The concluding section argues that Thatcherism bears historical and contemporary responsibility for making Britain a less healthy and more unequal place than it might otherwise be.

The political economy of Thatcherism

The political economy of Thatcherism was expressed succinctly in Thatcher's description of her intentions at the 1980 Conservative Party conference: 'the lady's not for turning' (10), which was a reference to the infamous U-turn of the 1970-74 Conservative government of Edward Heath. Heath had come to power on the basis of what we might now call a proto-neoliberal agenda, quite radically challenging the post-war social democratic settlement – the 'Keynesian welfare state'. His agenda attempted to undermine the power of organised labour by disengaging the state from failing ('lame duck') industries, using deflation to increase unemployment and changing trade union laws, while also attacking collective social welfare - notably the provision of social ('council') housing by elected local authorities (11). But Heath's attack was defeated by the industrial action of the British labour movement – by miners, dockers, shipyard and building workers, by Labour local authorities opposing his housing policy, and by a wide range of grass roots and community organisations which sprung up around the issues of unemployment and defending collective welfare provision (12).

Heath's about-turn was very clear: within two years of election, 'Heath rediscovered Keynes, turned reflationist, [and] turned 'lame ducks' into golden geese' (12). For a further two years the government limped on before Heath, against the background of a national miners' strike, and posing the question of who should govern Britain, called an election – which he lost. For the right wing of the Conservative Party, this was a humiliation. It began organising to take the leadership of the party in order to be in a position to pursue a more tenacious implementation of its vision for Britain, which it did when Margaret Thatcher defeated Heath in the 1975 party leadership contest.

In the years between 1975 and 1979 those around Thatcher – in particular Keith Joseph and Nicholas Ridley – developed detailed proposals for government (13). Their view was that the defeat of the movement which had forced Heath's U-turn would require, not simply the disengagement of the state from industry, but the substantial destruction of Britain's remaining industrial base. The full employment that had been sustained across most of the post-war period was seen, together with the broader security offered by the welfare state, to be at the root of an unprecedented self-confidence amongst working class communities (14, 15). In particular, large scale manufacturing and extraction industries, generally strongly unionized and often linked to the large scale provision of social housing at subsidized rents by local government, were seen to underpin a working class solidarity which gave that confidence a potent political expression (16). The windfall from the discovery of oil under the North Sea in the late 1970s became central to these New Right plans. Following Thatcher's election in 1979, highly permissive deals were struck with US firms to allow for rapid extraction. Thereupon, as Foster puts it: 'As the pound became a petro currency, it would be allowed to rise in international value. Capital would be exported on preferential terms. Very large-scale unemployment would end the 'cycle of rising expectations', permit the historic defeat of the trade union movement and then allow the repatriation of capital on its own terms'. (17, p.65) These were, in the phrase of Rodolfo Walsh, the economics of 'planned misery' – a 'greater atrocity' than even the many human rights violations which accompanied their implementation in Latin America (quoted in 18, pp. 95-96). This was fully understood by those who developed the plan for their implementation in Britain. Whole towns – indeed entire regions – would see the decimation of their economic bases and would become 'severely deprived'. But, as Ridley himself put it:

'there is no point in undertaking it if we are not prepared to go through with it' (19, p.4).

In 1978-9, the 'winter of discontent' arose when working people, via the trade unions, reacted with sustained industrial action to the Callaghan Labour government's attempt to impose an IMF-dictated incomes policy alongside public sector cuts. The Thatcherite New Right used its anti-union narrative to convince the public that the 'sick man of Europe' status of the British economy was a result of our social democracy and working class 'power' (4).

Shortly after the 1979 election which brought Thatcher to power, exchange controls were removed to allow an outflow of capital. Interest rates were increased from 12 to 14% and then again, by the end of the election year, to 17%. A 'veritable bloodbath' ensued (20). 'The depth of the recession had not been anticipated but those ... who were strongly influenced by monetarist thinking seized on it as an opportunity for forcing through ... radical changes' (21, pp.101-102).

The oil windfall was of further importance in both paying for the costs of the ensuing mass unemployment amongst the social groups and geographical regions worst affected, while also allowing for starkly regressive tax cuts for the better-off social groups and geographical areas least affected – thus helping to ensure a sufficient electoral base for the government (22). The government also implemented severe cuts in key areas of public expenditure. In housing, funding cuts forced sharp rent increases and undermined repair and improvement programmes in the council (public housing) sector. At the same time, council tenants were given a legal 'right to buy' their homes (23).

All of this had a growing impact on the nature of working class communities. The better off council tenants bought the best of the housing, whilst the younger economically active in the communities were forced out of the sector, leaving the oldest and poorest in the least desirable and often degenerating housing. As the relative value of benefits fell, and as wage rates for increasingly insecure and feminized, unskilled work were held down, the poorest were becoming poorer, and increasingly 'socially excluded', blamed and stigmatized for policy outcomes which the government had in fact fully anticipated in resolving to 'go through with it' (24).

'Going through with it', as Ridley put it, also required the aforementioned changes to trade union law and policing strategies for industrial disputes, together with a range of other preparations, to ensure the defeat of trade unions in particular industries at times selected by the government and employers (19). These plans were in due course faithfully followed' (21, p.103) – most infamously in the case of the 1984-85 miners' strike, which allowed the government to 'scare most other unions into acquiescence' (25, p.193).

But the 'repatriation of capital on its own terms' proved rather more problematic than had been anticipated. The new economy which emerged in the 1980s was of a seriously unbalanced kind. Manufacturing and extraction industries, public utilities and collective housing provision were displaced by finance and banking industries, privatised utilities, and rampant property speculation. The 'big bang' of 1986 saw the deregulation of the City of London and with that the unleashing of hitherto unimaginable forms of financial speculation. The ostensible 'giving power back to the people' through privatisation in fact led to the radical de-democratisation of the power industry – now largely externally owned – and other utilities. And the ambition to

create 'a nation of home owners' produced a mushrooming of homelessness due to a chronic shortage of affordable social housing – creating the preconditions for the more recent emergence of a new breed of 'buy-to-let' landlords charging 'market rents'. It also underpinned a new culture of speculation and chronic indebtedness – on which a new breed of amoral 'entrepreneurs' in banking and finance would be able to prey. All of this generated – and was designed to generate – sharply increased inequalities of income and wealth across Britain, and a dramatic increase in poverty. It also put in place most of the prerequisites for the great banking and finance crisis of 2008.

In this way Thatcher's governments wilfully engineered an economic catastrophe across large parts of Britain, and sowed the seeds, later nurtured by Blair's New Labour governments, of a subsequent collapse - which ironically has provided the highly spurious legitimation for a new generation of 'uber-Thatcherites' in the current Conservative - Liberal Democrat coalition government to go where Thatcher herself had hesitated to tread – a complete dismantling of the welfare state including the privatisation of the National Health Service (NHS) in England (9, 26).

Thatcherism, 'Big Business' and the Social Determinants of Health

Many of the changes outlined above were supported and promoted by the business community and occurred alongside the increasing incorporation of business interests into the management of the welfare state (27, p.473). In education, for example, state funding was cut and 'City Technology Colleges' were established with a view to involving business interests in establishing and funding secondary education (28).

The private sector was also encouraged to get involved in tackling youth unemployment and tendering for key government services (29).

The health impacts of the commercial sector's policy influence, and the close connections between senior politicians and commercial interests, were perhaps most overt in relation to tobacco. Under Thatcher's leadership, despite growing evidence of the negative health impacts of smoking (30), the tobacco industry remained influential and only very limited measures for controlling the marketing of tobacco were introduced (31). Subsequently, both Thatcher herself and one of her ministers, Ken Clarke (who held various high-level positions under Thatcher, including Secretary of State for Health) went on to work for large transnational tobacco companies; in 1992, ex-prime minister Thatcher signed up to work as a consultant for Philip Morris, whilst Ken Clarke became the Chair of British American Tobacco in 1998 (32).

Thatcherism was not only about the free market and the dominance of private interests, but also the 'strong state' (3). It was an 'authoritarian populist' project in which economic liberalism was accompanied by social conservatism and the reassertion of 19th century (Victorian) moral values (4). Social and ethnic minorities were subject to increased 'moral' and actual surveillance, for example, as a result of the 'stop and search' laws, which were disproportionately used by the police against young Black men and were implicated in the 1981 inner city riots in Brixton, London and Toxteth, Liverpool (33). Reforms to social assistance tended to be disciplinarian in nature, including the abolition of the earnings-related unemployment benefit supplement in 1982. Additionally, control over what was taught in schools was increasingly centralised; examples of this included the Education Reform Act in 1988

which introduced the National Curriculum, and also 'section 28' of the 1988 Local Government Act - the infamous clause which forbade the circulation of materials about, or the teaching of the 'acceptability of homosexuality as a pretended family relationship' in state schools.

These changes all led to a fundamental rebalancing of British economic and social life which saw a reassertion of social class divisions. The growing economic equality experienced as a result of UK social reforms since 1945 was reversed, with income inequality increasing significantly (for example, the richest 0.01% had 28 times the mean national average income in 1978 but this increased under Thatcher's tenure to 70 times in 1990) (34). Additionally, as a result of welfare state retrenchment, high unemployment and falling wages for many poorer workers (due to the decreased bargaining power of trade unions), there was a near doubling of poverty rates in the UK from 6.7% in 1975 to 12.0% in 1985 (7). Social mobility gains were also stalled via changes to the education system as well as the 'lost generation' of young people who left school and went straight onto 'the dole' in the early 1980s.

The impact of these changes on other key social determinants of health was, in many cases, dramatic. Inequalities in educational outcomes (35) and in access to healthcare (36), for example, both increased following policies implemented under Thatcher's leadership. In housing, Thatcher's government quickly implemented a 'right to buy' initiative, which as previously stated gave council tenants the right to purchase the homes they occupied, often at greatly discounted rates. This policy reflected the ideological belief in the superiority of the market and was popular amongst many of those it helped move into the housing market. However, it contributed to the growing wealth inequalities (37) and, more broadly, the policies of

Thatcherism sowed the seeds of the housing market crash in 1989, which left many home owners trapped by 'negative equity'. Meanwhile, as the better quality houses were sold off, local councils were left with responsibility for a far smaller and increasingly poor quality housing stock (37). All of this contributed to growing levels of homelessness (38).

Health Inequalities Policy

During Thatcher's period of governance concern about health inequalities focused on two areas – on specific social determinants of health and on the Black report and its legacy. Our present day understanding of the dynamics of health inequality largely post-dates Thatcher: it was only during the 1980s that many key material and psychosocial causes of health inequality – such as unemployment, income inequality and social isolation were first established (39, 40, 41). Thus the primary focus in the 1980s was on these and other known specific causes of health inequality. Causes which had been exacerbated by Thatcher's public policies, such as unemployment and poor nutrition, were often the subject of heated debate and government denial as to their health equity implications (42, 43, 44), since Thatcher would not permit 'the nanny state' to 'interfere' in what she regarded as individual decisions about people's health.

The 1980 Black report (45, 46) which had been commissioned in 1978 by Labour and its 1987 successor The Health Divide (46, 47) were critical and comprehensive reviews of health inequalities research and policy in the UK and overseas. Both were

famously marginalised and suppressed by Thatcher's government – and both achieved wide and immediate attention as a result (48). Both carried unpalatable messages for Thatcher. The Black report reviewed long-term trends in mortality inequalities by occupational social class. It considered alternative causal explanations, including artefact, selection and culture, concluding that structural / material inequalities were undoubtedly the main cause of health inequality. It made wide ranging recommendations including child poverty reduction policies and increases in welfare benefits and it was no surprise that its findings were immediately rejected by Thatcher's government (49, 50).

The Health Divide reviewed progress in the seven years since the Black report and concluded that health inequalities had steadily increased during the 1980s. Its wide ranging recommendations for public policy were similarly rejected. Despite this negative scenario, much local action around health inequalities was promoted by Labour local authorities and non-governmental organisations (51). Academics and activists were also legitimated in their health equity activities by the World Health Organisation's Health for All Strategy, the first of whose 38 European targets was a 25% reduction in health inequalities by the year 2000. (52). While the UK was a signatory to the strategy, its health inequalities aspects continued to be disregarded throughout Thatcher's period of office.

A typical example of this relates to the 1986 publication of the 10 yearly Occupational Mortality Supplement to the 1981 national census (53). For the first time, virtually all of the data on social class were made available only in microfiche and hence were effectively unavailable to the general public. The official reason

given related to changes in the social class classification – even though this could have been overcome by aggregating and then comparing data from non-manual and manual occupational classes. Indeed, the lead author of the supplement did precisely this in a research paper published simultaneously with the supplement's release (54), which demonstrated significantly widening class inequalities in Britain. The British Medical Journal was so incensed by the effective suppression of the inequalities data that it published these allegations in an editorial provocatively entitled 'Lies, damned lies and suppressed statistics' (55).

The Rise of Managerialism and Markets in the NHS

Thatcher's approach to the NHS 'problem' was highly contradictory. Despite commissioning radical proposals from the government's Central Policy Review Staff in 1982 which would have led to a dismantling of the welfare state and the replacement of the NHS by a health insurance system, in the end the NHS remained remarkably untouched during her time in office. In her memoirs, Thatcher admitted that, in most areas, the NHS delivered high quality care at reasonable cost. She also acknowledged that the service commanded 'as much affection as exasperation' (56). But while Thatcher backed off any wholesale reform of the NHS, allegedly fearful of an adverse public reaction to such a move, her government did introduce a number of policy initiatives which set the NHS on a course from which it has not deviated since. That course might be characterised as a shift from a welfare state to a market state (57).

The two most significant NHS developments which took place under her premiership were linked and involved first, subjecting the NHS to a particular form of

managerialism which in turn led directly to the introduction of a quasi-market in health care centred around competition and choice (58).

As noted above, the business sector was held in high regard by Thatcher's governments and Thatcher often invited prominent businessmen into government to conduct reviews of efficiency in order to demonstrate how public services could learn from what she instinctively believed to be a leaner and fitter private sector. Roy Griffiths, a former Chair of the Sainsbury's supermarket chain, was among the first to fulfil this role: his 23 page 'letter' to ministers in 1981 led to the introduction into the NHS of general management, accompanied by a cadre of health authority chief executives (59). Although Griffiths had expected existing managers and clinicians to take on this role, many of those initially recruited were drawn from business and the armed forces: few survived.

The tension between management and medicine has been a long-standing one, with successive NHS reorganisations from 1974 onwards seeking to limit clinical freedom and power while strengthening the grip of management over resources and priorities (59). While management of any type may be anathema to some clinicians, what has dismayed many is the particular brand of managerialism which the Thatcher government, and others since, endorsed and what it has led to.

The British NHS was an early pioneer of management reforms following its first major reorganisation in 1974 which was largely based on work and concepts developed by a combination of the management consultancy McKinsey (whose close association with the NHS remains to the present day) and a team from Brunel University. But arguably the managerial revolution in health care did not really get underway until the 1980s and 1990s under the banner of 'new public management'

(NPM). NPM became an international trend in public administration and it proved attractive to policy-makers in many health systems besides the UK's. Hood (60) describes NPM as comprising seven doctrines:

- a focus on hands-on and entrepreneurial management, as opposed to the traditional bureaucratic focus of the public administrator
- explicit standards and measures of performance
- an emphasis on output controls
- the importance of disaggregation and decentralisation of public services
- a shift to the promotion of competition in the provision of public services
- a stress on private sector styles of management and their superiority
- the promotion of discipline and economy in resource allocation.

Conceivably, NPM would have been introduced regardless of who held power in Britain at the time since its market-based thinking enjoyed wide appeal across the political spectrum and health system reform had become something of a global industry. Nonetheless, what happened in the UK occurred during Thatcher's tenure and as it happens, chimed perfectly with her values and ideology which viewed public services as bloated, inefficient, unresponsive to user (or, increasingly, consumer) preferences and often ineffective and poorly performing. She may have felt unable to go further in subjecting the NHS to the full rigours of the marketplace, for reasons that were not always consistent or clear - but she did enough to allow her legacy to be built on and taken further by her successors from both main political parties.

Among the most controversial changes Thatcher introduced was the policy of contracting out or outsourcing, introduced in 1983, whereby health authorities were required to set up competitive tendering arrangements for their cleaning, catering and laundry services. Additional non-clinical services were later added to the list. The main significance of this development was the establishment of the principle that the core responsibility of health authorities was no longer to directly provide non-clinical services but merely to ensure that they were in place at least cost. A key negative impact was a loss to the public sector ethos of the NHS in which for example, cleaners were perceived as members of the ward team whose friendly, reassuring presence made important contributions to the well-being of patients. This contribution disappeared once the tight schedules of competitive contract cleaning took over. Equally important was the perception that ward cleaning became substantially less thorough, leading over time to the current high prevalence of hospital acquired infections (61).

The managerial grip was further tightened with the appearance in 1989 of the government's plan for NHS reform, *Working for Patients* (62) which led to the NHS and Community Care Act 1990. Its proposals drew directly on NPM-type thinking and introduced market-style mechanisms into the NHS, notably the purchaser-provider separation and general practitioner (GP) fundholding whereby GPs were allocated budgets which they were free to spend as they saw fit, to meet their patients' needs. Such proposals may seem rather timid and insubstantial in retrospect, especially as the purchaser-provider separation failed to confront entrenched provider power as was intended (and as remains the case under present day commissioning) and GP fundholding fizzled out as most GPs did not warm to it. But at the time, the

Conservative government's NHS changes were regarded as marking a break with the past and as opening the NHS up to market forces. The use of the term 'internal market' may have given the impression that the creation of a market would be confined to the public sector and off limits to the private sector but this was misleading - although the government was nervous about allowing market forces to take off.

The real significance of Thatcher's NHS reforms lay not in what they themselves achieved but in putting in place some key system changes which positioned the NHS in readiness for subsequent developments which occurred under New Labour (1997-2010) and under the UK Coalition Government from mid-2010. The basic architecture evident in many of the controversial changes contained in the Health and Social Care Act 2012 (9) clearly has its origins in the changes implemented by Thatcher and in the work of New Right think tanks which shared her ideology and politics (63, 64).

Mortality, health and well-being in the Thatcher years

Mortality rates in the UK, and across western and central Europe, have been improving for around 150 years (65). This long-run improvement continued throughout the period of the Thatcher government, with all-cause mortality rates declining at a similar rate to those in other countries and compared to the time periods before and after (Figure 1). However, underlying the overall improvement in mortality rates, some specific causes of mortality increased markedly either during the period of the Thatcher government, or immediately afterwards. For example,

alcohol-related mortality increased dramatically during the late 1980s and early 1990s in the UK in contrast to the improving trends in other parts of Europe (Figure 1). Increases were also seen in drug-related mortality, suicide and violence at this time (66, 67, 68); all of which are causes of death which are clearly socially produced rather than due to biological or physiological mechanisms.

Within the UK, mortality rates improved much more slowly in Northern and inner city areas than in the more affluent Southern England (69), to the extent that in some areas mortality rates actually worsened (70). Indeed, for young adults in Scotland there has been no improvement over the course of the last 30 years (71).

The rise in spatial inequalities in health during the 1980s (72) was also reflected in a rapid rise in mortality inequalities by occupational social class in England and Wales and by area deprivation in Scotland (73). Figure 2 shows that the absolute gap in mortality (as measured by the Slope Index of Inequality) between the least and most deprived postcode areas in Scotland remained high but stable between 1981 and 2001; whilst relative inequalities (as measured by the Relative Index of Inequality) increased rapidly to leave Scotland with the highest inequalities in western and central Europe (74, 75). In England and Wales, life expectancy increased for all social class groups amongst males and females over time, but the increase was more rapid amongst social classes I+II than in social classes IV+V, such that the inequalities increased.

The rise in health inequalities witnessed in Britain during the 1980s and 1990s was large, but not unprecedented. Other countries which adopted neoliberal policies also saw rises in health inequalities, such as the USA and New Zealand (76). It would be wrong to assume that such rises in health inequalities are in any sense inevitable:

from the 1920s to the 1970s in both Britain and the USA, inequalities in mortality declined at the same time as income inequalities were reduced and the welfare state was built up (72, 77).

Figure 3 gives some insight into the causes of the rises in health inequalities seen in Britain during this time. As outlined above, the combination of policies implemented under Thatcher led to a rapid rise in unemployment rates. From 1980, the number of unemployment claimants rose from around 1 million to around 3 million in 1983; a further peak was seen in the early 1990s. Meanwhile there was a steady rise in the number of claimants of long-term sickness (disability) benefits. The rise in the number of disability benefit claimants has been attributed to a government desire to move people off the unemployment register and because of the lack of jobs in the economy (78). Figure 3 also shows that the 1980s saw a rapid increase in income inequalities and poverty rates. By the 1990s and 2000s, these new high levels became normalized.

The rises in cause-specific mortalities such as alcohol- and drug-related deaths, suicide and violence, and the widening health inequalities, occurred during the same time period in which unemployment, poverty and income inequality all rose. The antecedents of these types of cause-specific mortality, and of health inequalities, are well-explored in the literature; reviews of this evidence highlight the importance of social and economic determinants of health (79). Given what we know about the impact of Thatcher's neoliberal reforms on the social and economic landscape of Britain, it seems clear that Thatcher's legacy includes the unnecessary and unjust premature death of many British citizens, together with a substantial and continuing burden of suffering and loss of well-being.

Conclusions

There can be no doubt that Thatcherism had a major impact on the health and wellbeing of the British population. Although overall population health continued to improve by many measures (e.g. in terms of mean mortality rates and infant mortality), it improved more slowly than in other comparable countries (65).

Meanwhile, within-country health inequalities increased, both in terms of class and geography. Post-industrial areas, notably in Scotland, fared particularly badly (65).

The aggressive promotion of free market policies under Thatcher was accompanied by the growing influence of business interests, a commitment to reducing the size of the welfare state, the acceptance of widespread, unequally distributed unemployment and the implementation of a range of authoritarian social policies. All of this suggests Thatcherism contributed to ensuring Britain became a less healthy and more unequal place than it might otherwise have been. Thatcher's neoliberal project was subsequently strengthened and more firmly embedded by her successors in Conservative (Major) and Labour (Blair and Brown) governments. Its legacy is especially visible in the policies currently being pursued by the post-2010 Conservative / Liberal Democrat UK coalition government (26).

References

1. O'Hagan, A. Maggie. *The New York Review of Books*, May 23, 2013.
<http://www.nybooks.com/articles/archives/2013/may/23/maggie/?pagination=false>
(accessed June 27, 2013).
2. Bambra, C., Fox, D., and Scott-Samuel, A. Towards a politics of health. *Health Promotion International* 20:187-193, 2005.
3. Gamble, A. *The Free Economy and the Strong State*. London, Macmillan, 1994.
4. Hall, S., and Jacques, M. (eds.). *The Politics of Thatcherism*. London, Lawrence and Wishart, 1983.
5. Malik, S. *Representing Black Britain: Black and Asian Images on Television*. London, Sage, 2002.
6. Moran, M. *Governing the Healthcare State: A Comparative Study of the UK, the USA and Germany*. Manchester, Manchester University Press, 1999.
7. Ginsburg, N. *Divisions of Welfare: A critical introduction to comparative social policy*. London, Sage, 1992.
8. BBC. Budgets 1979-1992.
http://www.bbc.co.uk/news/special/politics97/budget97/background/bud1979_92.shtml
(accessed June 27, 2013).
9. Davis, J., and Tallis, R. (eds.). *NHS SOS: How the NHS Was Betrayed and How We Can Save It*. London, Oneworld, 2013.
10. American Rhetoric Online Speech Bank. Margaret Thatcher: The Lady's Not For Turning.

<http://www.americanrhetoric.com/speeches/margaretthatchernotforturning.htm>

(accessed June 27, 2013).

11. Foster, J., and Woolfson, C. How workers on the Clyde gained the capacity for class struggle: The Upper Clyde Shipbuilders work-in, 1971-72. In *British Trade Unions and Industrial Politics: The High Tide of Trade Unionism?, 1964-79*, eds. A. Cambell, N. Fishman, and J. McIlroy. Ashgate, Aldershot, UK, 1999.
12. Roth, A. *Heath and the Heathmen*. London, Routledge and Kegan Paul, 1972.
13. Woolfson, C., Foster, J., and Beck, M. *Paying for the Piper: Capital and Labour in Britain's Offshore Oil Industry*. London, Mansell, 1997.
14. Phillips, J. *The Industrial Politics of Devolution: Scotland in the 1960s and 1970s*. Manchester, Manchester University Press, 2008.
15. Foster, J. The twentieth century. In *The New Penguin History of Scotland*, eds. R. A. Houston, and W. W. J. Knox. Penguin, London, 2001.
16. Collins, C., and McCartney, G. The impact of neoliberal 'political attack' on health: The case of the 'Scottish Effect'. *Int. J. Health Serv.* 41: 501-523, 2011, doi: 10.2190/HS.41.3.f.
17. Foster, J. The economic restructuring of the West of Scotland: 1945-2000. In *Restructuring Regional and Global Economics: Towards a Comparative Study of Scotland and Upper Silesia*, ed. G. Blazyca. Ashgate, Aldershot, UK, 2003.
18. Klein, N. *The Shock Doctrine: The Rise of Disaster Capitalism*. London, Penguin, 2007.
19. Ridley, N. Final Report of the Policy Group on the Nationalised Industries. London, The Conservative Research Department, 1977.

20. Elliot, L. Margaret Thatcher was loved and hated – both for sound economic reasons. *The Guardian*, 14 April, 2013.
<http://www.guardian.co.uk/business/2013/apr/14/margaret-thatcher-loved-hated-economic> (accessed June 27, 2013).
21. Gamble, A. *The Free Economy and the Strong State: The Politics of Thatcherism*. London, Macmillan, 1988.
22. Jessop, B., et al. *Thatcherism: A Tale of Two Nations*. Cambridge, UK, Polity Press, 1988.
23. Forrest, R., and Murie, A. *Selling the Welfare State: The Privatisation of Public Housing*. London, Routledge, 1988.
24. Jones, O. *Chavs: The Demonization of the Working Class*. London, Verso, 2012.
25. Overbeek, H. *Global Capitalism and National Decline: The Thatcher Decade in Perspective*. London, Unwin Hyman, 1990.
26. McKee, M., and Stuckler, D. The assault on universalism: how to destroy the welfare state. *BMJ* 343: 2011, doi: 10.1136/bmj.d7973
27. Farnsworth, K., and Holden, C. The Business-Social Policy Nexus: Corporate Power and Corporate Inputs into Social Policy. *J. Soc. Pol.*, 35:473–94, 2006.
28. Dale, R. The Thatcherite project in education: The case of the City Technology Colleges. *Critical Social Policy* 9:4-19, 1989.

29. Robertson, D. R. Mrs. Thatcher's employment prescription: An active neoliberal labor market policy. *Journal of Public Policy* 6:275-96, 1986.
30. Peto, R. Smoking and death: the past 40 years and the next 40. *BMJ* 309: 937-39, 1994.
31. Cairney, P. A 'multiple lenses' approach to policy change: the case of tobacco policy in the UK. *British Politics* 2:45-68, 2007.
32. Gilmore, A., and McKee, M. Tobacco control policy: the European dimension. *Clinical Medicine* 2:335-42, 2002.
33. Bowling, B., and Phillips, C. Policing ethnic minority communities. In *Handbook of policing*, ed. T. Newburn. Willan Publishing, Cullompton, UK, 2003.
34. Dorling, D. How social mobility got stuck. *New Statesman*, 16 May, 2013. Available at: <http://www.newstatesman.com/media/2013/05/different-class> (accessed June 27, 2013).
35. Gillborn, D., and Mirza, H. S. *Educational Inequality. Mapping Race, Class and Gender: a Synthesis of Research Evidence*. London, Office for Standards in Education, 2000.
36. Ham, C. Reforming Health Services: Learning from the UK Experience. *Social Policy & Administration* 28:293-98, 1994.
37. Dorling, D. *All That is Solid*. London: Penguin, in press.
38. Loveland, I. The politics, law and practice of "intentional homelessness": 2–Abandonment of existing housing. *Journal of Social Welfare and Family Law* 15:185-199, 1993.
39. Moser, K. A., Fox, A. J., and Jones, D. R. Unemployment and mortality In the OPCS Longitudinal Study. *Lancet* 324:1324-29, 1984.

40. Wilkinson, R. G. Income and mortality. In *Class and Health: Research and Longitudinal Data*, ed. R. G. Wilkinson. Tavistock, London, 1986.
41. Berkman, L., and Syme, S. Social networks, host resistance, and mortality: a nine-year follow-up study of Alameda County residents. *Am. J. Epidemiol.* 109:186-204, 1979.
42. Smith, R. *Unemployment and Health: A Disaster and a Challenge*. Oxford, Oxford Medical Publications, 1987.
43. Bartley, M. *Authorities and Partisans: The Debate on Unemployment and Health*. Edinburgh: Edinburgh University Press, 1992.
44. Robbins, C. Implementing the NACNE report. 1. National dietary goals: a confused debate. *Lancet* 322:1351-53, 1983.
45. Department of Health and Social Security. *Inequalities in Health Research Working Group*. London, DHSS, 1980.
46. Townsend, P., Davidson, N., and Whitehead, M. *Inequalities in Health: The Black Report and The Health Divide*. London, Penguin, 1988.
47. Whitehead, M. *The Health Divide*. London, Health Education Council, 1987.
48. Anon. The Health Divide: Swan-song of the Health Education Council. *Lancet* 329:724-26, 1987.
49. Gray, A. M. Inequalities in health. The Black Report: a summary and comment. *Int. J. Health Serv.* 12:349-80, 1982.
50. Berridge, V., and Blume S., eds. *Poor Health: Social Inequality Before and After the Black Report*. London, Frank Cass, 2003.

51. Scott-Samuel, A. Social inequalities in health: back on the agenda. *Lancet* 327:1084-85, 1986.
52. World Health Organisation. *Targets For Health For All*. Copenhagen, WHO Regional Office For Europe, 1985.
53. Office of Population Censuses and Surveys. *Occupational Mortality Decennial Supplement, 1979-80, 1982-3*. London, HMSO, 1986.
54. Marmot, M. G., and McDowall, M. E. Mortality decline and widening social inequalities. *Lancet* 328:274-76, 1986.
55. Lies, damned lies, and suppressed statistics. *BMJ* 293:349, 1986, doi <http://dx.doi.org/10.1136/bmj.293.6543.349>
56. Thatcher, M. *The Downing Street Years*. London, HarperCollins, 1990.
57. Bobbitt, P. *The Shield of Achilles: War, Peace and the Course of History*. London, Penguin, 2003.
58. Hunter, D. J. *The Health Debate*. Bristol, Policy Press, 2008.
59. Harrison, S., et al. *Just Managing: Power and Culture in the National Health Service*. Basingstoke, UK, Macmillan, 1992.
60. Hood, C. A public management for all seasons? *Public Administration* 69:3-19, 1991.
61. Davies, S. Fragmented management, hospital contract cleaning and infection control. *Policy and Politics* 38:445-463, 2010.
62. Secretaries of State for Health, Northern Ireland, Wales and Scotland. *Working for Patients*. Cm. 55. London, HMSO, 1989.

63. Letwin, O. *Privatising the World: A Study of International Privatisation in Theory and Practice*. London, Cassell, 1988.
64. Pirie, M, and Butler, E. *The Health Alternatives*. London, Adam Smith Institute, 1988.
http://www.adamsmith.org/sites/default/files/images/uploads/publications/The_Health_Alternatives.pdf (accessed June 27, 2013).
65. McCartney G., et al. Has Scotland always been the 'sick man' of Europe? An observational study from 1855 to 2006. *European Journal of Public Health* 21:1-5, 2011, doi 10.1093/eurpub/ckr136
66. World Health Organization. *Health for All Database*. Geneva, WHO, 2012.
67. Shaw, M., Dorling, D, and Davey Smith, G. Mortality and political climate: how suicide rates have risen during periods of Conservative government, 1901-2000. *Journal of Epidemiology and Community Health* 56: 722-27, 2002.
68. Mok, P. L. H., et al. Trends in national suicide rates for Scotland and for England & Wales, 1960-2008. *British Journal of Psychiatry* 200:245-51, 2012.
69. Hacking, J. M., Muller, S., and Buchan, I. E. Trends in mortality from 1965 to 2008 across the English north-south divide: comparative observational study. *BMJ* 342:d508, 2011, doi <http://dx.doi.org/10.1136/bmj.d508>
70. Norman, P., et al. Rising premature mortality in the UK's persistently deprived areas: Only a Scottish phenomenon? *Soc Sci Med* 73:1575-84, 2011.
71. Whyte, B., and Ajetunmobi, T. *Still the 'sick man of Europe'? Scottish mortality in a European context 1950-2010. An analysis of comparative mortality trends*. Glasgow, Glasgow Centre for Population Health, 2012.

72. Thomas, B., Dorling, D., and Davey Smith, G. Inequalities in premature mortality in Britain: observational study from 1921 to 2007. *BMJ* 341:c3639, 2010.
73. Leyland, A. Increasing inequalities in premature mortality in Great Britain. *Journal of Epidemiology & Community Health* 58:296-302, 2004.
74. Mackenbach, J. P., et al. Socioeconomic inequalities in health in 22 European countries. *New England Journal of Medicine* 358:2468-81, 2008.
75. Popham, F., and Boyle, P. *Assessing socio-economic inequalities in mortality and other health outcomes at the Scottish national level*. Edinburgh, Scottish Collaboration for Public Health Research and Policy, 2010.
76. Beckfield, J., and Krieger, N. Epi + demos + cracy: Linking political systems and priorities to the magnitude of health inequities - evidence, gaps, and a research agenda. *Epidemiol Rev* 31:152-77, 2009, doi 10.1093/epirev/mxp002
77. Krieger, N., et al. The fall and rise of US inequities in premature mortality: 1960-2002. *PLoS Medicine* 5:e46, 2008, doi:10.1371/journal.pmed.0050046
78. McVicar, D. Why have UK disability benefit rolls grown so much? *Journal of Economic Surveys* 22: 114-39, 2008.
79. Independent Inquiry into Inequalities in Health. Report. London, The Stationery Office, 1998, <http://www.archive.official-documents.co.uk/document/doh/ih/ih.htm> (accessed June 27, 2013).

Figure 1 - Trends in all-cause and chronic liver disease mortality in UK compared to selected European countries, 1970-2009 (Source: European Health for All Database, World Health Organization)

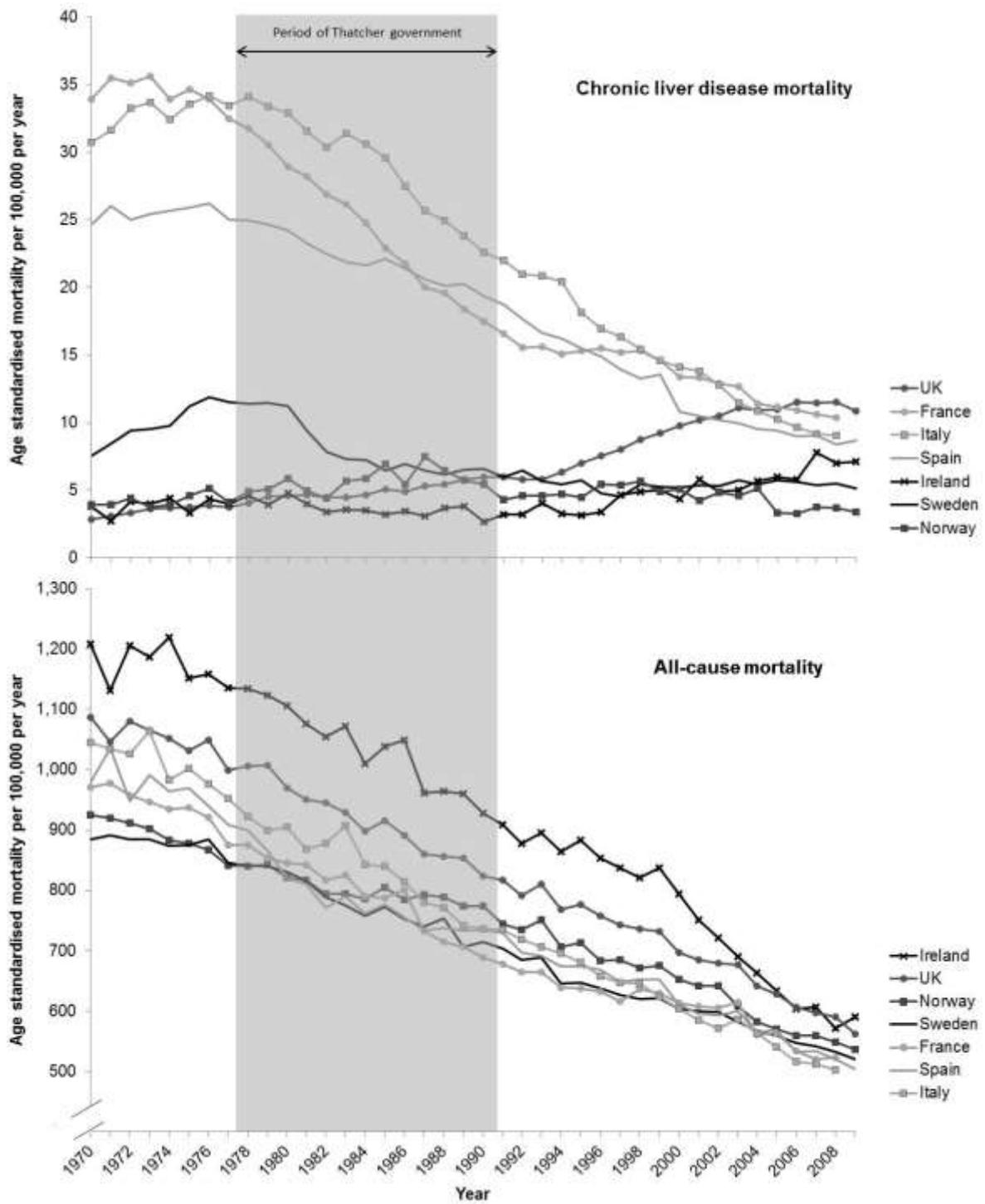


Figure 2 - Trends in health inequalities in England & Wales 1975-2003 (by occupational social class) and Scotland 1981-2001 (by Carstairs area deprivation)
(Sources: National Records for Scotland and Office for National Statistics)

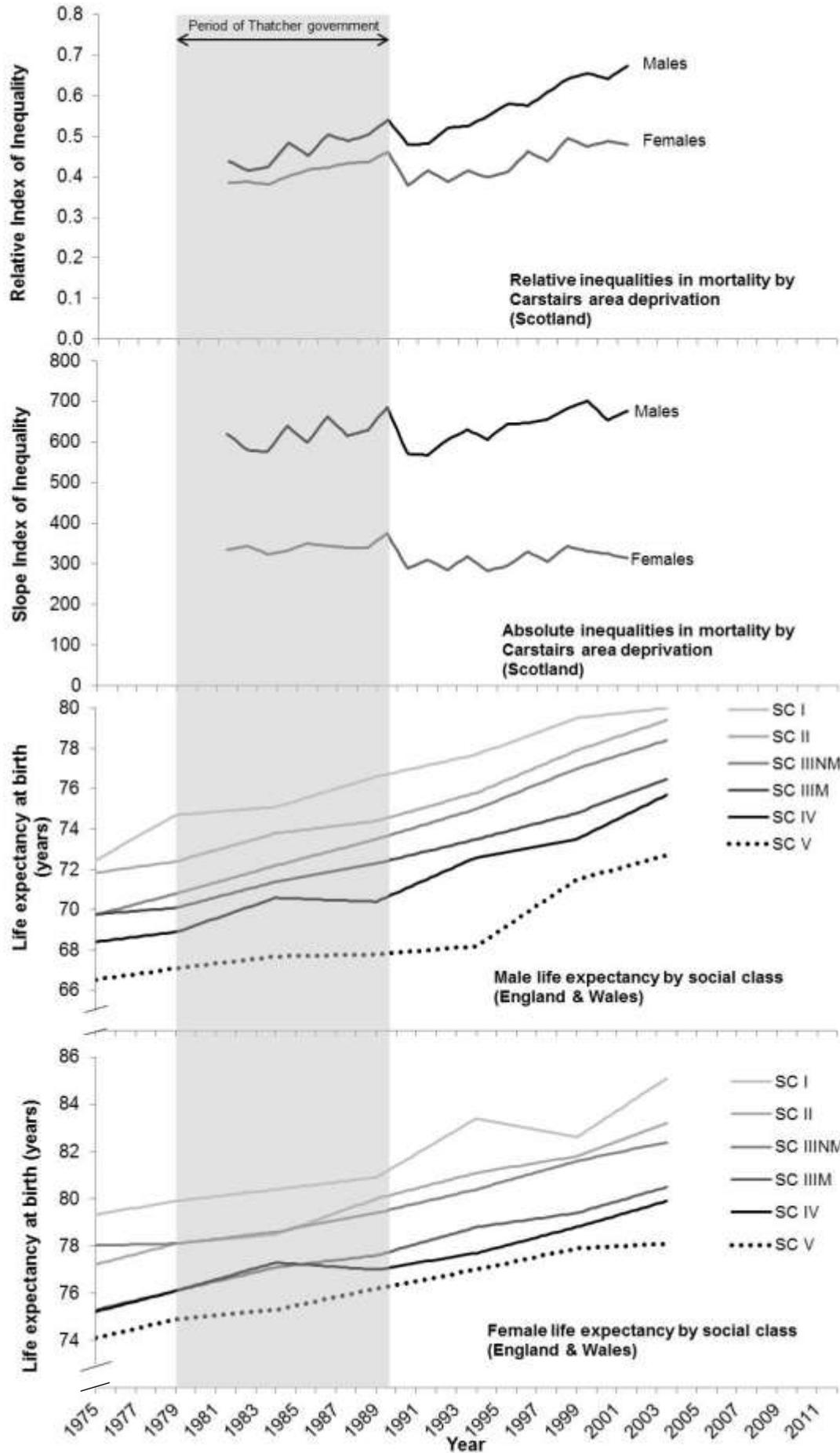


Figure 3 - Trends in relative poverty (income <60% median income), income inequality (measured by the Gini coefficient) and the number of claimants of unemployment and long-term (>6 months) sickness benefits* in Great Britain (1975-2012) (Sources: Institute of Fiscal Studies, Department for Work and Pensions, Office for National Statistics).

*Long-term sickness benefits included are: Invalidity Benefit, Incapacity Benefit, Severe Disablement Allowance, Employment Support Allowance)

