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The British National Health Service 1948–2008: A Review of the Historiography

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Summary. This article surveys historical writing on the British National Health Service since its inception in 1948. Its main focus is on policy-making and organisation and its principal concerns are primary care and the hospital sector, although public health, and psychiatric and geriatric care are briefly discussed. The over-arching narrative is one of transition from paternalism and technocratic planning to market disciplines and a discourse of choice, and of the ceding of professional autonomy by clinicians to managers and to the state. These issues are discussed in a chronological survey of policy-making from Bevan's 'creation' to the Blair era. Later sections consider evaluations of the service, starting with Webster's thesis that the NHS has been subject to prolonged under-funding, particularly under Conservative stewardship, then moving to assessments of the Thatcher, Major and Blair reforms. Much of the historical literature on the NHS is contentious and opinions are sharply divided on the reform era since the 1970s and the trajectories this has set for the future.

Keywords: National Health Service; historiography; primary care; hospitals; welfare state; policy; financing

Sixty years on, and the beginnings of the National Health Service (NHS) fade into history, its founders long dead and its early workforce slipping beyond the reach of oral testimony. How should it be remembered? For politicians who traffic in ideals and aspirations, the story is simple. On the one hand, those of all stripes cleave to the populist ideal of the NHS as 'an enduring institution which has earned a special place in our country', and whose 'founding principles . . . have stood firm, providing a quality service for all, regardless of ability to pay'.[1] Yet despite decades of management and structural reform it is also characterised as a relic of the past, the sympathetic depicting it as a 'command and control' organisation analogous to the post-war nationalised industries, and the hostile declaring it more bluntly to be Stalinist.[2] Professional historians lament such reductionist postures, which they see as symptomatic of their broader exclusion from networks of policy formation.[3] Meanwhile, much historical writing on the NHS emanates from the policy community and concentrates on the very recent past. Where historians

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[1]Major 1996; Blair 1998*a*, p. ix.
[2]Blair 1998*b*, p. 15; Mohan 2003; Bone 2008.
[3]Berridge 2007*a*.

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themselves have grappled with the long view the results have, unsurprisingly, been 'mixed messages, diverse interpretations'.[4] This anniversary therefore provides a useful opportunity to take stock of what has been written and to identify the main analytical trends.

How should the parameters of the subject be drawn? At its simplest, the NHS is the structure which began on the 'appointed day' of 5 July 1948, whose purpose was to provide universal, comprehensive and free health care, with ultimate responsibility residing in the minister appointed by the governing party. From the start, this public supply has dominated UK health services, with private insurance never exceeding 12 per cent population coverage.[5] Hence it is a field of study at once small and manageable, and vast and unwieldy. Setting aside the value-laden comparisons (its size 'surpassed only by the Chinese Red Army') the scale of the NHS is undeniable; in 1951, hospital staff alone numbered over 400,000, rising to 1,166,000 by 2004.[6] This makes social historians' usual caveats about distilling unitary narratives from plurality of experience all the more pertinent. The dominant genre has therefore been a top-down history of the politics of the service, whose *dramatis personae* are the politicians, officials, doctors, intellectuals and pressure groups driving the policy process. Such a history is also, needless to say, highly contentious. Almost from the outset the NHS has acted as a lightening conductor for ideological fissure, for some an incarnation of social solidarity and distributional justice, for others the epitome of inflexible bureaucracy and paternalism. Nor is this simply ideological, as scholars deploying psychoanalytic insights like to remind us. For the NHS also functions as metaphor, a 'social imaginary' whose 'unspoken mission' is the 'collective protection from painful realizations of death and decay, and ensuring symbolic survival at a less conscious and thus less rational level'.[7]

In approaching the literature it is striking how few texts deal with the long history of the organisation, with fewer still from within the discipline. Of the studies of the welfare state, those of Timmins (to 1993) and Lowe (to 2005) treat the NHS within broader accounts of social policy, the former with journalistic insight, the latter from the analytical perspective of 'reluctant collectivism'.[8] The earliest survey of the service is Ross's (to 1951), which uses historical argument to analyse how policy should respond to financial austerity.[9] Next came major studies by Eckstein (to 1959) and Lindsey (to 1961), both North Americans examining the pros and cons of 'socialised medicine'.[10] Subsequent works include that by Watkins (to 1974), in which historical sections preceded a critical assessment of the 1974 reorganisation, and Widgery (to 1977), a fierce response to the 1970s funding squeeze from the East End socialist GP.[11] The reorganisation also prompted accounts of two axed Regional Hospital Boards, Leeds and

[4]Stevens 2000, p. 806.
[5]OHE 2007, p. 121, data 1955–2005.
[6]Johnson 2007; OHE 2007, p. 139.
[7]Elkind 1998; Fotaki 2006, pp. 1718, 1720; Fontaine 2002, p. 434.
[8]Timmins 1995; Lowe 2005, pp. 47–8.
[9]Ross 1952, pp. 369–74.
[10]Eckstein 1959; Lindsey 1962.
[11]Watkin 1978; Widgery 1979.

Wales.[12] Several more contemporary texts dealing with shorter phases have appeared: Mohan on the Thatcher/Major years and Paton on New Labour, for example.[13] An official history was commissioned in 1980 and thus far two volumes have been issued, both by Webster, covering the pre-legislative period from about 1940, up until 1979 and the fall of the Callaghan administration.[14] These inevitably concentrate on political and administrative matters, though both contain economic data and medical history.

There are only three widely circulated texts spanning the whole of the NHS's existence. These are the concise political histories by Webster (whose second edition closes in 2002) and Klein (whose fifth edition extends to 2006), and Rivett's fiftieth anniversary study, which emphasises clinical and organisational matters alongside policy (and is updated online to 2008).[15] These works will form the spine of the ensuing discussion, not least because Webster and Klein exemplify respectively the leftist and centrist poles of political interpretation. (The NHS has not received a fundamentally sceptical, neo-liberal historical critique, beyond minor works by writers linked with the Institute of Economic Affairs (IEA).)[16]

Because of their importance, some background is needed on these three authors. Webster is an academic historian who initially worked on early modern science studies, and in his political history he makes transparent the sympathies which he muzzled in the official publications. His admiration goes to Bevan, he portrays Labour as the founder and protagonist of the NHS with the Conservatives always more reluctant stewards, and he attributes the failings of the service to chronic under-funding and botched administrative reforms. Klein began his career as an *Observer* journalist, switching to academia in the early 1970s with his disciplinary base in 'the art of policy analysis'.[17] History, sociology and political science inform his work, and his footnotes are peppered with his own contemporary commentaries on policy developments in health and social care.[18] Viewing himself as a 'middle-man' between policy-makers and academics, he adopts an ambivalent posture, acknowledging his sympathy for the Conservative internal market reforms and their intellectual progenitor, Alain Enthoven.[19] Rivett, by contrast, worked first as a GP, before joining the Department of Health in 1972, where his tasks included the implementation of the Conservative reforms of primary health care, 1985–92.[20] As a policy insider he is loyal to the NHS (Tony Blair wrote a glowing foreword), mostly eschewing critical assessment in favour of a record of events relying heavily on the *Lancet* and *BMJ*.[21] So, in these writers the NHS has three elegant and

[12]Ryan 1974; Ham 1981.
[13]Mohan 1995; Paton 2006.
[14]Webster 1988, p. ix, 1996, p. xi.
[15]Webster 2002: the first edition was 1998; Klein 2006: earlier editions were 1983, 1989, 1995 and 2001; Rivett 1998, 2008.
[16]For example, Jewkes and Jewkes 1961.
[17]Klein in Oliver (ed.) 2005, p. 143.
[18]For example, Klein 1973, chs 3 and 4.
[19]Klein in Oliver (ed.) 2005, pp. 145, 150.
[20]Rivett 2008, 'Geoffrey Rivett'.
[21]Stevens 2000, p. 809.

authoritative chroniclers, Webster and Klein staking out distinct political positions and Rivett providing a comprehensive work of reference.

Beyond these core texts there is a huge range of other relevant material. Illuminating, if sometimes self-serving, insight is provided by the memoirs and biographies of ministers and civil servants; of the latter, Pater on the 'making', Smee on health economics and policy-making, and the recent study of the Chief Medical Officers deserve mention.[22] The many medical specialities have their historians, some clinicians, others social scientists, with greater or lesser interest in the organisational framework of practice. Primary care has a limited literature, the essays in the edited *Oxford History* of 1998 superseding earlier studies by Stevens and Fry.[23] Hospitals are covered by Mohan and Rivett (on London), though both treat the NHS era as part of longer surveys.[24] Oral histories of post-war British medicine are proliferating, thanks to the Wellcome Witness Seminars and the British Library Sound Archive, although the NHS is chiefly the context and not the object of study.[25] Finally, health has long had a dominant position in the social policy literature, and studies of administrative structures and performance include much historical work within contextual discussion or retrospective evaluation of 'service delivery'.[26] The same can be said of health economics and, more recently, of management studies.

What follows, then, will by necessity be limited largely to the NHS's political history. At its crudest the dominant story of the NHS today is of a fairly stable institution in its early decades, which then entered a period of sustained reform characterised by the incursion of market disciplines. One explanatory framework sets this arc of change against the sweep of social transformation in Britain, from post-war collectivism to fully-fledged consumer society.[27] Thus Alan Milburn, (Secretary of State for Health, 1999–2003) depicts the adaptation of a 'monolithic' service wedded to the 'one size fits all approach of the 1940s' to 'a consumer age', an 'informed and inquiring society', in which patients 'expect choice and demand quality' through more individualised services.[28] If political shorthand abbreviates a complex history, passing over developments in patient representation dating at least to the 1960s, the central argument enjoys some support.[29] Klein summarises this transition as one 'from church to garage', a metaphor which lampoons both the uncritical faith of 'Old Labour believers' in the Bevan model and the low commercialism of 'garagiste' Tories. Essentially his motif encapsulates a shift 'from paternalism to consumerism, from need to demand, from planning to choice'.[30] Similarly Pickstone describes a changing political economy of medicine from mid-twentieth century 'communitarianism', shaped by notions of inclusiveness and faith in biomedicine, to a new consumerism, compounded of greater assertiveness towards health and fertility,

[22] Pater 1981; Smee 2005; Sheard and Donaldson 2006.
[23] Loudon *et al.* (eds) 1998; Stevens 1966; Fry 1988.
[24] Rivett 1986; Mohan 2002.
[25] See http://www.ucl.ac.uk/histmed/publications/wellcome_witnesses_c20th_med and http://www.bl.uk/collections/sound-archive/holdings.html#health (accessed 9 June 2008).
[26] Powell 2006, pp. 238, 242.
[27] Pickstone in Cooter and Pickstone (eds) 2000.
[28] Milburn 2002.
[29] Ham and Alberti 2002, p. 839.
[30] Klein 2006, pp. 253–4.

the commodification of the body and the expansion of the private medical marketplace.[31] Thus the state's role in medical care has shifted from an expression of social solidarity and public service to a means of satisfying the preferences of increasingly 'autonomous' patients.[32]

Others are more sceptical about popular consumerism as a motive force. Political economy approaches emphasise instead the vulnerability of the British welfare state within the context of national and global capitalism. The shift to a service economy and rising prosperity undermined the old Labour electoral constituency, while the need to attract international investment pushed governments to adopt lower tax regimes and open up the public sector to business; waiting in the wings was the international health care industry, poised to benefit from trade liberalisation.[33] Whether foregrounding structural factors, or the agency of reforming politicians, texts adopting this perspective treat the Bevanite NHS as optimal, not simply because of its aspirations to equity and redistribution, but because it decommodified the medical labour process, placing an ethos of service above that of profit. Pollock's work is the best known exemplar, arguing for the deleterious effects of market values and privatisation, and critical of the long march from integration to fragmentation, with the accompanying denigration of rational planning.[34] For all accounts with a long view, though, the key period of transition can be located between the mid-1970s and late 1980s. First, the service was destabilised by the checks on spending following the oil shock, while the 1974 restructuring proved an ineffective panacea. Then came the true turning point, the Thatcher era, with constrained expenditure, the assault on medical corporatism, the internal market, and all that has followed.[35]

Therefore, the meta-narrative might be described as one of 'church to garage' or 'communitarianism to marketisation', and the interpretive positions, as will become clear, encompass both those who treat this as flexible adaptation and those fiercely opposed to the reform trajectory. Armed with these preliminary reflections, the initial discussion proceeds chronologically, identifying the periodisation around which the key themes and debates have emerged, then exploring these. Here the focus is on policy-making and organisation and, given the constraints of space, it concentrates on primary care and on the hospital sector. At the same time, it briefly notes those areas of the service whose history stands apart from the central narrative. The closing section surveys evaluative works and asks how these feed in to historical readings.

Foundation

The founding of the NHS is marked by debate over whether a broad consensus existed in favour of reform, or whether change was the outcome of conflict between progressive and reactionary forces.[36] Klein is in the former camp, noting the alliance of paternalistic bureaucrats and 'medical technocrats' who championed rationalisation and

[31] Pickstone 2003, pp. 3, 14–16.
[32] *Ibid.*; Coulter 2002, p. 33.
[33] Paton 2006, pp. 1–42; Leys 2001, pp. 1–80, 165–210; Holden and Farnsworth 2006.
[34] Pollock 2004, pp. 222–4.
[35] Doyal and Doyal 1999, pp. 365–6.
[36] Webster 1990.

integration.[37] Also influential is Fox's analysis of interwar 'hierarchical regionalism', the trend towards the spatial organisation of medical services around centres of expertise.[38] Local case studies lend empirical weight to this, tracing emergent groupings of medical academics, local government health officials and industrialists, notably in urban hospital councils.[39] However, examples also abound of continuing inefficiencies of the pre-1948 voluntary hospital system and of impediments to joint working.[40] Webster has made the strongest case for the NHS as the outcome of confrontation between the Labour Party, increasingly supported by public opinion, and more conservative forces.[41]

The key account of organised labour's health policies prior to 1948 is Earwicker's unpublished thesis, tracing experimentation in local government and the debates over whether universalism should be achieved through insurance or state provision.[42] Stewart's work on the Socialist Medical Association, influential both nationally and in London, has further enriched the story of the Left's contribution.[43] The case for a pivotal role for social democratic movements in promoting universalism and equity in health systems also features in the comparative literature, and it may be that examining the 'conflict/consensus' debate in other national contexts will further illuminate the British case.[44]

Acts of 1946 and 1947 established the NHS as universal, comprehensive and free at the point of use, funded by general taxation; the voluntary hospitals were nationalised and managed by unelected Regional Hospital Boards (RHBs) alongside ex-local government institutions, while GPs were administered separately and local authorities were left with residual public health and social care functions. The fullest descriptions of the political machinations leading up to the reform are provided by Honigsbaum and Webster.[45] Several studies analyse the acts as outcomes of pressure group politics, and comparative histories also emphasise the relative powers of the state, corporate medicine and other health care providers to shape health systems reform.[46] The critical role of Aneurin Bevan in boldly amending the stalled proposals of the coalition government is commonly accepted, and Webster has illuminated the postwar policy context from which his ideas sprang.[47] Of Bevan's biographers, Foot is admiring and Campbell more critical, highlighting the abandonment of a local authority-run health service in favour of the tripartite system, which perpetuated divisions between the surgery and hospital, and health and social care.[48] Was this the best that could be achieved by a great political pragmatist, or a loss of nerve in the struggle with the BMA, as Lowe suggests?[49]

[37] Klein 2006, pp. 19–21.
[38] Fox 1986.
[39] Sturdy 1992; Pickstone 1985, pp. 279–93; Hull 2001; Gorsky 2004.
[40] Gorsky and Mohan 2001; Gorsky 2004; Mohan 2002, pp. 31–7, 42–4, 49–59.
[41] Webster 1988, pp. 390–3; Webster 1990; Webster 2002, p. 255; Jacobs 1993, pp. 115–17, 185–7.
[42] Earwicker 1982.
[43] Stewart 1997, 1999.
[44] Elling 1994; Navarro 1976.
[45] Honigsbaum 1989; Webster 1988, chs ii–iv.
[46] Willcocks 1967; Eckstein 1960; Eckstein 1964, pp. 109–63; Gorsky, Mohan and Willis 2005; Immergut 1992; Wilsford 1991.
[47] Webster in Goodman (ed.) 1998.
[48] Foot 1973; Campbell 1987, pp. 176–9, and see Stewart 2002.
[49] Lowe 2005, pp. 184–5.

Scepticism about Bevan's model of a tax-financed NHS, with the attendant risk of 'institutionalising parsimony', is implicit in Klein's reading and made explicit by Portillo, though within a partisan case for extending private insurance.[50]

The First Phase, 1948–1979

The survey texts then delineate an initial phase of consolidation encompassing most of the 1950s (Webster until 1957, Rivett and Klein to 1958). A key backdrop was the curb on government expenditure under the Churchill administration, after it became apparent that initial financial projections had drastically underestimated costs while suppressed demand surged.[51] Ironically it was high public satisfaction with the NHS which allowed politicians to neglect it in favour of education and social security, as Cutler points out.[52] Only following the favourable evaluation of the Guillebaud Committee in 1956 were 'the years of sackcloth and ashes' over and growth reinstated.[53] The austerity of the Conservative 1950s is at the heart of Webster's second assault on the 'consensus' reading of the early NHS, which also castigates Tory stewardship for increased charges and a growing reliance on the more regressive national insurance 'NHS contribution'.[54]

Otherwise the verdict on the 1950s is that only the acute hospital sector made progress. Even though capital investment remained lower than in the 1930s, major strides were made in developing the full-time consultant service. If Ham's case study is generalisable then it also appears that the potential of an integrated service to rationalise the distribution of staff was fulfilled.[55] Medical authority is also supposed to have been unrestrained; in Le Grand's caricature this was a 'command and control' system with 'rather few commands and precious little control'.[56] Management historians use terms like 'diplomats' and 'kindly technicians' to summarise the hospital administrators' role in ensuring a smoothly functioning environment for clinicians.[57] By contrast, primary care is depicted as suffering financial and political neglect, buffeted by critical reports, and marked by low prestige and high workloads.[58] Emblematic of its stagnation for Webster was the abandonment of the health centre programme, initially intended to link the local authority community services to general practice and thus a lynchpin of the tripartite structure.[59] Eckstein argues that Labour lost interest in health centres as other spending priorities loomed, though Ryan challenges this, attributing the policy shift to the Conservatives, with their BMA-friendly strategy of developing primary care by bolstering private group practice.[60]

[50]Klein 2006, p. 253; Portillo 1998.
[51]Cutler 2003; Klein 2006, pp. 25–30; Appleby 1999, pp. 83–4.
[52]Cutler in Gorsky and Sheard (eds) 2006.
[53]Klein 2006, p. 46.
[54]Webster in Oakley and Williams (eds) 1994.
[55]Ham 1981, pp. 82–6; and see Eckstein 1959, pp. 232–6, Ryan 1974, pp. 16–18.
[56]Le Grand 2003, pp. 48–9.
[57]Harrison and Lim 2003; Harrison and Ahmad 2000, p. 132; Learmonth 1998, p. 325.
[58]Morrell in Loudon *et al.* (eds) 1998, pp. 1–6; Bosanquet and Salisbury in Loudon *et al.* (eds) 1998, pp. 46–50.
[59]Webster 1998*a*, pp. 21–6.
[60]Eckstein 1959, pp. 247–52; Ryan 1968, pp. 36–9.

The NHS then entered a 'long 1960s', whose backdrop was a substantial rise in real expenditure which lasted until 1972–3 and the subsequent oil price hike.[61] Technocratic intervention reached its zenith in the Hospital Plan of 1962 under Enoch Powell (Minister of Health, 1960–3), which proposed a national hierarchy of district general hospitals and subsidiary centres for defined populations, backed by a substantial capital programme for new building. Klein treats this as the apotheosis of paternalistic faith in planning, attributing its subsequent failures to the short-sightedness of both politicians and the BMA, who preferred spending on projects with more immediate gains.[62] However, Mohan urges a more generous evaluation of the Plan's modest achievements (which he contrasts favourably with recent policies of hospital decentralisation), emphasising instead adverse external circumstances, such as lack of capacity in the construction industry.[63]

The 1960s also signify a 'turning point' and 'years of growth' for historians of primary care, as the new Family Practitioner Contract negotiated with Kenneth Robinson (Minister of Health, 1964–8) gave incentives for progressive GPs to innovate.[64] Group practice was encouraged, attachments by community nurses became more common, support staff ran appointment systems and improved record keeping, and even the health centre scheme resumed, championed by George Godber (Chief Medical Officer, 1960–73).[65] These developments are closely related to innovative intellectual currents, such as Balint's work on the doctor/patient dynamic and Tudor Hart's emphasis on social determinants of morbidity.[66] Oral histories confirm a growing confidence in the professional status of general practitioners, now better integrated locally with hospital consultants.[67] Some, though, dissent from this benign narrative, such as Esmail, who regards 1960–75 as a time of growing professional discrimination against ethnic minority doctors, instilling an enduring 'pariah' status.[68]

The 1970s are characterised as years of disruption and disillusion, whose main features were administrative restructuring and worsening labour relations, as the years of plenty came to a close.[69] The 1974 reorganisation of the NHS ended the tripartite system, aligning hospital and local government services within a tiered structure of area and district health authorities. The official history details the long deliberative phase which preceded this reform. Analysis of its gestation points to ministerial frustration at the slow development of community care facilities and the unresponsiveness of the RHBs to central policy goals for psychiatric hospitals.[70] Appraisal of the reorganisation has been unadmiring, partly because the district tier soon proved unworkable and was removed, and partly

[61] Appleby 1999, pp. 83–4.
[62] Klein 2006, pp. 46–9, 56–7; and see Lowe 2005, pp. 192–5.
[63] Mohan 2002, pp. 154–7; Mohan 2003.
[64] Morrell in Loudon *et al.* (eds) 1998, pp. 6, 9.
[65] Webster 1998*b*, pp. 26–34; Bosanquet and Salisbury in Loudon *et al.* (eds) 1998, pp. 50–3; Jeffreys 1998, pp. 140–5.
[66] Marinker in Loudon *et al.* (eds) 1998, pp. 71–8, 84–7.
[67] Smith and Nicolson 2007.
[68] Esmail 2007, pp. 830–2.
[69] Timmins 1995, pp. 313–68.
[70] Lowe 2005, pp. 195–6.

because of the negative impact on public health.[71] Watkins was the first to historicise this episode's 'dismal outcomes', attributed to its 'bureaucratic complexity' and excessive centralisation.[72] Central planning produced one further innovation, in the Resource Allocation Working Party (RAWP) formula, intended to distribute expenditure more equitably between the regions. Mays and Bevan explain the RAWP's origins in terms of a favourable political juncture (the 1974 reorganisation, coupled with the advocacy of David Owen) and increasing academic interest in inequalities and refining indicators of need; Welshman by contrast stresses the influence of academic health economists.[73]

The technocratic state was unsuccessful in appeasing the NHS's workforce, as spending curbs provoked industrial action by nurses, junior doctors and ancillary workers. Klein ascribes the growth of labour militancy to competition between the unions for members, and the disruptive effect of incomes policies on traditional pay differentials.[74] Harrison, too, emphasises the under-developed and fragmented nature of the health unions, whose achievements compared poorly to other industries.[75] The boldest statement of the left perspective is Widgery's, whose 1979 history concludes with chapters on 'the cuts' and 'trade unionism' and argues that industrial action was the only bulwark of the patient's interest against the 'sleek administrators' leading the NHS 'into the abyss'.[76] Interpretations also diverge on Barbara Castle's handling of the dispute over the consultants' contracts and the ending of pay beds within the NHS; for Rivett the 'damage she inflicted on the NHS is hard to over-estimate', while Higgins, no enthusiast for private medicine, laments Castle's lack of pragmatism over an issue of primarily symbolic significance.[77] Webster is more generous, noting that Castle was tied to party and trade union policy, and in other respects proved a remarkably effective health minister.[78]

'Thatcherization'

Though the survey texts treat the Thatcher and Major years separately, the Conservative hegemony of 1979–97 arguably forms a discrete period in the NHS's political history. General accounts of the welfare state view this as a watershed, marked by restrained public spending, confrontation with corporate interests and the imposition of market disciplines.[79] All these were features of the 'Thatcherization' of the NHS.[80] Real expenditure grew at a lower rate than at any time since the early 1950s, apart from 1989–93, when it rose to grease the wheels of organisational restructuring.[81] Also a more 'thrusting' style of management was introduced, strengthening the hands of bureaucrats over

[71]Lowe 2005, p. 196; Isom and Kandiah (eds) 2002, pp. 60–1; Berridge *et al.* (eds) 2006, pp. 9–12, 18.
[72]Watkin 1978, pp. 162–3.
[73]Mays and Bevan 1987, pp. 5–30; Welshman in Gorsky and Sheard (eds) 2006.
[74]Klein 2006, pp. 80–1.
[75]Harrison 1988, pp. 67, 79.
[76]Widgery 1979, pp. xiv, 129.
[77]Higgins 1988, pp. 79–83.
[78]Webster 1996, pp. 620–7, 746–9.
[79]Lowe 2005, pp. 2–3, 315–39.
[80]Webster in Loudon *et al.* (eds) 1998, p. 38.
[81]Appleby 1999, pp. 83–4.

clinicians.[82] Private sector involvement was encouraged through contracting support services and promoting private medical insurance (PMI). A defining moment was the Griffiths Management Inquiry of 1983, which led to the appointment of an NHS chief executive, and the ending of 'consensus management', whereby health authority decisions required approval by a multidisciplinary team.[83] Learmonth unpacks the discursive shift from 'administrator' to 'manager' which followed, detecting in this new usage a reconstitution of the executive as a belligerent, heroic leader facing down consultant intransigence.[84] Early evaluations found the Griffiths reform to have been only partially effective, with no infusion of new personnel, and little evidence that clinical autonomy was restrained.[85] However, Harrison argues that the legitimacy of general management was established, heralding a more assertive period in the reform era that followed.[86]

This was the introduction in 1989 of the internal market, founded on a purchaser–provider split whereby primary care procured services from hospitals, the aim being to improve efficiency through 'managed competition'. Particularly intriguing is the debate over the genesis of this change, for Thatcher's ideological commitment had hitherto been tempered by concern over the political combustibility of NHS reform. Butler's 1992 study is a first draft of this history, emphasising the combination of media pressures, Enthoven's ideas, and continuity with existing management reforms which fed into her review. Describing the White Paper as 'an exercise in hopeful prescribing', with perhaps a hidden agenda of speeding privatisation, Butler emphasises the key role of Kenneth Clarke in driving the unpopular reforms through Parliament.[87] A 2002 Witness Seminar which gathered academics, politicians and doctors' leaders further illuminates the issue, suggesting that extreme neo-liberal ideology was never a serious factor; indeed, government was concerned to deflect electoral suspicions of covert intentions to privatise the NHS.[88] Probably the intellectual influence of Enthoven (who, Webster caustically notes, had cut 'his teeth on the military disaster of the Vietnam War') has been overdone; instead homegrown health economists like Maynard and Bosanquet mattered more.[89] Nor does Clarke's vainglorious claim to have conceived GP fund-holding on a Spanish holiday stand up.[90] It is also clear that electoral concerns forced the pace of reform and undermined proposals for gradualness.

Given the confrontational rhetoric of Thatcherism, it is unsurprising that commentaries on the Conservative policies are also oppositional. Klein is broadly sympathetic, viewing Thatcherism as a product of the societal changes of deindustrialisation and emergent consumerism: she 'rode the waves rather than creating them'.[91] For him the crisis of the welfare state arose not from underfunding but from an unwillingness to adapt to changing circumstances (partly thanks to hidebound social policy academics); thus the

[82] Edwards 1995, p. 83.
[83] Harrison 1988, p. 16.
[84] Learmonth 2001, 2005.
[85] Harrison and Lim 2003.
[86] Harrison and Ahmad 2000, p. 134.
[87] Butler 1992, pp. 48, 56, 98–103, at p. 103.
[88] Isom and Kandiah (eds) 2002, evidence of Willets, Bosanquet, Dorrell, pp. 31, 37–8.
[89] Webster 2002, p. 187.
[90] Timmins 1995, p. 464; Fry 1988, pp. 110–11.
[91] Klein in Oliver (ed.) 2005, p. 148.

Tory project was an essentially technical exercise, drawing on more diverse 'policy recipes' than hitherto available.[92] The absence of piloting was not irrational policy-making driven by electoral calculation; instead government recognised that perfect outcomes were unattainable and that 'adaptive policy learning' from the process of implementation was a legitimate strategy.[93] Moreover, despite the perception that the reforms were inherently destructive, their outcome was to preserve the NHS intact within the welfare state, on which overall spending increased during the Conservative years.[94]

Others disagree. Clinician-historians are particularly outspoken against health care being 'treated as a commodity like cars, shoes, or baked beans'.[95] Disinterested opinion is hard to disentangle from professional self-interest, though Freeman's concern that marketisation 'undermined' the 'ethical' and 'humanitarian traditions' of the NHS is heartfelt.[96] Webster's analysis exemplifies the leftist charge-sheet, deploring sustained under-investment, lack of electoral transparency, reliance on the advisory role of accountants and business-people, and unwillingness to consult broadly or to pilot radical initiatives.[97] Crucially, he regards the Thatcher reforms as an ideological project whose agenda was an assault on collectivism.[98] Kleinian readings which claim that beneath all the bluster the NHS's core principles had been little affected are also criticised. In a prescient piece from 1987, Davies argued that apparently incremental changes were opening the door to a new era of 'welfare pluralism', while Ruane later made a similar case, that managerialism and the 'valorisation of labour' had cumulatively eroded distinctions between the NHS and private medical markets.[99]

New Labour: 1997–2008

To the extent that it can yet be historicised, the Blair era divides into two phases. The first saw a softening rather than rejection of the internal market, with purchasing replaced by commissioning and GP fundholders by Primary Care Groups, and the acceleration of the Private Finance Initiative (PFI) building programme. The second began in 2000 with 'the most expensive breakfast in history', Blair's televised interview pledge to raise NHS spending to the European Union average.[100] Insider testimony from Smee clarifies the route to this funding injection. Hitherto demographic data had persuaded government economists that NHS funding levels were broadly correct, and an annual inflator was calculated based on population change, new technology costs and relative price effects.[101] Only with the arrival of smarter performance indicators, such as comparative cancer mortality, coupled with firm evidence of patient dissatisfaction was complacency overturned.[102] The new money was accompanied by further reforms, attributed particularly to socialist

[92]Klein in Oliver (ed.) 2005, p. 148; Klein 2006, pp. 106–8, 111–12, 148.
[93]Klein 2006, p. 157–8, 162–6, at p. 166; Klein in Oliver (ed.) 2005, p. 152.
[94]Klein 2006, p. 146; Klein in Cooter and Pickstone (eds) 2000, pp. 159–62; and see Lowe 2005, pp. 370–4.
[95]Morrell 1998, p. 15; Freeman 1995, p. 668.
[96]Freeman 1999*a*, p. 4.
[97]Webster in Loudon *et al.* (eds) 1998, pp. 39, 43; Webster 2002, pp. 146–7, 150–3, 163–4, 183–4, 193.
[98]Webster 2002, pp. 140–5.
[99]Davies 1987; Ruane 1997.
[100]Klein 2006, p. 187.
[101]Smee 2005, pp. 14–17.
[102]Smee 2005, pp. 24–7, 73–6.

turned moderniser, Alan Milburn. These promoted more local autonomy, through foundation trust status for hospitals, a raft of new patient and public involvement (PPI) bodies to institutionalise 'choice', and, ironically, the further elevation of the 'command-and-control' weaponry of clinical governance: audit, regulation and performance management.[103] Harrison argues that this signalled the final triumph of the manager as purveyor of 'scientific-bureaucratic medicine'. Armed by the state with National Institute for Health and Clinical Excellence (NICE) guidelines and the National Service Frameworks standards, health service executives now wielded unprecedented power over clinical practice.[104]

Whether or not this policy mix is a new trajectory is uncertain. It is certainly arguable that Blairism signifies a shift to a 'consumerised' mixed economy of welfare, clearly distinguished from statist and market approaches by, for example, the new localism.[105] At present, however, the evidence inclines more to the view that New Labour represents policy continuity in its main strands: commissioning, the conceptualisation of the patient as consumer, PFI and hospitality towards the private sector.[106] Historical judgements of New Labour's handling of the NHS reflect this uncertainty. Webster's history ends in 2002 with cautious praise that at least a substantial rise in expenditure has occurred.[107] Klein too offers qualified enthusiasm for a pragmatic 'attempt to combine the best features of the church with the most attractive characteristics of a garage . . . a drive-in church'.[108] While acknowledging that decision-making was sometimes influenced less by measured judgement than short-term calculation, he suggests that government interventions should be understood sympathetically as policy learning through implementation.

Opinion is more divided on individual aspects. PPI's recent history has attracted particular interest, with scholars tracking the changing forms, from the Community Health Councils (CHCs) set up in 1974 and abolished by Milburn in 2003, to the use from 1992 of focus groups, citizens' juries and opinion polling, and finally to New Labour prescriptions of Patients' Forums and hospital membership communities.[109] At best this has made managers more reflexive and accountable, even if evidence for the meaningful exercise of patient choice between providers remains thin.[110] At worst they were the machinery of legitimation, by which managers utilised superficial consultation to justify their own decisions: in this reading, the demise of the CHCs signalled the replacement of oppositional bodies by toothless representation.[111] The early record of PFI has also attracted criticism, both on the grounds of poor value for money and its disruption of needs-based capital development.[112] The most vehement assault comes from Pollock, whose early critical stance on PFI blossomed into a more sweeping condemnation of

[103]Klein 2006, p. 222.
[104]Harrison and Ahmad 2000, pp. 135–6.
[105]Froggat 2002, pp. 15–28.
[106]Webster 2002, p. 140, 218; Lowe 2005, pp. 421–2, 431–4; Leys 2001, ch. 6; Paton 2006.
[107]Webster 2002, p. 257.
[108]Klein 2006, p. 255.
[109]Milewa *et al.* 1998, pp. 508–10.
[110]Milewa *et al.* 1999, pp. 461–2; Newman and Kuhlmann 2007, pp. 107–8.
[111]Harrison and Mort 1998; Webster 2002, pp. 241–6.
[112]Mohan 2002, pp. 203–10.

private sector incursion into 'NHS plc'. She argues that the founding principles of the NHS are already lost: universalism, through the abandonment of the RAWP and the reappearance of geographical inequities; comprehensiveness, through the cessation of eye services, capping of NHS dentistry and removal of long-term care to the local authorities; and free access, through cost-shifting to patients for intermediate and long-term care, and the routine offer of private elective surgery.[113] For Pollock, privatisation is driven both by the ideological convergence of New Labour and Conservatism, and by the global interests of the health care industry, buttressed by the prescriptions of the World Trade Organisation.[114] Historians may find some idealisation in the depiction of the early NHS, but hers is a challenging polemic.

Three Subaltern Narratives

Before turning to historical evaluations of the NHS, we should briefly note three significant areas of the health service which stand somewhat apart from the grand narrative outlined above. The first is public health, where the story is one of 'decline, fall and rise'. The others are the long-term care of psychiatric and elderly patients, where the issue of deinstitutionalisation looms large.

The declinist analysis of public health was established by Lewis in the 1980s, tracing the marginalisation of Medical Officers of Health (MOsH), who were victims of restructuring in 1948 and 1974, but also authors of their own downfall, failing to forge a new philosophy of preventive medicine relevant to the post-war environment.[115] Case studies are slightly more generous to the MOsH, although Berridge's history of tobacco control reaffirms the impotence of local public health professionals in the NHS.[116] Instead, the centre of gravity moved to national government and its interplay with industry, research scientists and the voluntary sector.[117] Revival since the 1990s is signalled in a recent Witness Seminar, attributed to the impact of AIDS, the 1988 Acheson Inquiry and international influences of the new public health.[118]

A central theme of psychiatry in the NHS is the shift since the 1960s from institutional to community care. This is not a process which scholars have viewed as liberating or humane, nor is there consensus on the cause. Some, such as Freeman and Jones, regard the old asylums as essentially benign institutions whose demise was due to the unhappy conjunction of Conservative cost-cutting and wrong-headed anti-psychiatry doctrines.[119] The claim that new anti-psychotic drugs explain 'decarceration' is dismissed by Scull, who argues that the fiscal stresses of welfare capitalism fell first on unproductive 'problem populations'; Moncrieff's recent assault on the 'myth of the chemical cure' undergirds the argument that it was economics, not effective pharmacotherapies

[113]Pollock 2004, pp. 33, 36–40, 78–80.
[114]Pollock 2004, pp. 9–17, 60–2.
[115]Lewis 1986.
[116]Welshman 1997; McLaurin and Smith 2002, Berridge 2007*b*.
[117]Berridge 2007*b*, chs 3–6.
[118]Berridge *et al.* (eds) 2006.
[119]Freeman 1999*b*, pp. 7–9; Hunter in McLachlan (ed.) 1987, pp. 339–42; Jones 1993, pp. 159, 169, 170–4, 178, 194, Jones 1996, pp. 475–6.

which explain deinstitutionalisation.[120] Empirical studies have complicated the picture, for example tracing 1950s antecedents to community care, early therapeutic optimism attending chemotherapies, and peculiar local factors which first favoured small psychiatric units in district general hospitals rather than asylums.[121] There is general agreement, however, that community care has been a disappointment, although it remains moot whether this was due to political complacency or to 'calculated neglect' in the interest of preserving resources for the acute sector.[122]

A third subaltern history is that of long-term care for the elderly. Here too there is a trajectory of decarceration and community care, and a theoretical framework which emphasises the productionist features of welfare states, with their tendency to allocate fewer resources to economically inactive groups.[123] The NHS began with a phase of optimism, as the new specialty of geriatric medicine promised to overcome the therapeutic nihilism which hitherto attended 'chronic sick' hospitals.[124] However, the needs of elderly patients cut across both the NHS and local authority social welfare departments, and Bridgen and Lewis have charted the tensions over bed-blocking and cost-shunting which arose because neither side was adequately funded.[125] Bridgen also condemns the Ministry of Health for failing to give a lead in hospital development plans, while Martin links neglect to the persistence after 1948 of Poor Law attitudes.[126] In Bridgen and Lewis's analysis, the lack of clarity over NHS and local government responsibilities was a constant feature between the 1940s and 1990s, obscuring a covert agenda to restrict hospitals to acute care, while also impeding the development of comprehensive community services.[127]

Evaluations and Historical Trajectories

Before examining evaluations of the NHS in its different phases, we should first consider a central theme in Webster's analysis: that the NHS has suffered from cumulative underfunding throughout its existence. For example, austerity in the Conservative 1950s was 'an arrest in development from which it was virtually impossible for the NHS to recover', while the crises of the Thatcher era and the subsequent catalogue of reforms all stemmed from the decision to squeeze inputs.[128] His argument is most fully illustrated for the period up to the 1970s, turning on the suppression of real current expenditure from 1950 to 1957; the paltry capital investment in the 1950s; the failure of spending as a proportion of GDP to recover its 1950 level until 1964/5; and the inability of health to increase or even hold its share of UK social expenditure.[129] Qualitative evidence

[120] Scull 1977, pp. 79–89, 134–53, at p. 137; Moncrieff 2008, pp. 50–4, 60–1, 220–2.

[121] Busfield 1986, pp. 326–46; Welshman in Bartlett and Wright (eds) 1999, pp. 224–5; Mayou 1989; Pickstone in Pickstone (ed.) 1989.

[122] Hunter in McLachlan (ed.) 1987, pp. 348–9; Martin 1984, ch. 5, pp. 169–71; Payne in Bartlett and Wright (eds) 1999, p. 251; Webster 1996, pp. 117–26.

[123] Means and Smith 1998, pp. 8–9.

[124] Thane 2002, pp. 436–57; Lindsey 1962, pp. 469–70.

[125] Bridgen and Lewis 1999.

[126] Bridgen 2001; Martin 1995, p. 461.

[127] Bridgen and Lewis 1999, pp. 113–21.

[128] Webster in Oakley and Williams (eds) 1994, p. 70; Webster 2002, p. 153.

[129] Webster 1996, pp. 801–3. Social expenditure comprises the NHS, education, social services, social security and housing.

that under-funding prevented British patients from accessing beneficial treatments available elsewhere can certainly be found, as in Stanton's exposure of 'covert rationing' in renal dialysis.[130] But is it really possible to assess how much is enough to meet demands for health care?[131]

One approach to this is to take population health as an indicator. On these terms it was initially argued that the NHS was very good value for money, achieving similar mortality rates at a cheaper cost than other countries, notably the United States.[132] However, neither were the NHS's outputs markedly in advance of European countries with different systems.[133] It remains possible that even better results would have been achieved with greater investment, and recent studies of mortality from diseases amenable to health service provision confirm the general proposition that, in the post-war period at least, health services matter to health outcomes.[134] This was recently acknowledged when Labour raised expenditure to comparable European levels and the Wanless report (2002) attributed capacity constraints to 'past inadequate investment'.[135]

Rather less supportive of the 'under-funding' case is the approach of Appleby, whose output indicator is hospital productivity.[136] When real expenditure 1949/50 to 1996/7 is set against trends in productivity no clear relationship is discernible, and indeed in some periods rising throughput accompanied spending curbs. Appleby speculates (with his eye on the recent past) that managerial reform and new incentive structures were generating improvement even in the absence of more cash.[137] This, though, is contestable. Throughput is a blunt instrument with which to measure total NHS output, revealing nothing of quality and subject to other influences, such as technological advance. Nor is the causal link between rising throughput and post-1979 managerialism straightforward, since major productivity growth also occurred in the parsimonious and statist 1950s. Thus the jury remains out on the under-funding thesis, though *en passant* we should note that Appleby buttresses Webster's view of the Left's greater financial commitment: up to 1997, Labour administrations consistently spent more on the NHS, increasing funding in real terms by on average 3.75 per cent per annum, against 2.33 per cent under the Conservatives.[138] Party difference is even more pronounced in the recent period: Conservative: 2.6 per cent (1992/3–1996/7), Labour: 6.1 per cent (1997/8–2007/8).[139]

Turning now to evaluations of the early period NHS, it is striking that despite the dismissals of contemporary politicians, historians have been generally kind to the Bevan model. Lindsey's 1962 verdict was most effusive, although it may be that his real

[130]Stanton 1999.
[131]Roberts 1989, pp. 65–6; Klein 2006, pp. 142–6, 220–2.
[132]Anderson 1972, ch. x; Hollingsworth 1990, pp. 38, 73–8, 107, 191–8.
[133]Watkin 1978, pp. 152–4.
[134]Nolte and McKee 2004, p. 38. Such findings challenge McKeown's famously sceptical position on this issue, see Nolte and McKee 2003, p. 3.
[135]Wanless 2002, p. 17.
[136]Appleby 1999, pp. 87–8. Specifically the throughput measure is hospital discharges and deaths; he argues that his expenditure series is more robust than either Webster's or the Office of Health Economics' series, in that it shows government spending net of other inputs, pp. 80–1.
[137]Appleby 1999, p. 87.
[138]Appleby 1999, p. 84.
[139]Rivett 2008, ch. 6A, 'Finance', unreferenced citation of Appleby.

agenda was to persuade US public opinion that 'socialised medicine' was no ogre.[140] While critical of the constrained capital programme and the barriers erected by the tripartite system, he concluded that the vision of the Beveridge Report 'has become an impressive reality'.[141] Webster's long view also leads him to lionise the first phase, although he too is mindful of shortcomings, particularly with respect to the Cinderella services and the health/social care boundary. None the less, for him 'Bevan's health service fully deserves the positive image by which it is remembered': it extended access, addressed an accumulated backlog of demand, improved the position of health care workers, satisfied public opinion, and engendered *esprit de corps* amongst professionals who delivered services 'with compassion and sincerity'.[142]

Klein denies the possibility of impartial evaluation, as in the pluralist polity the NHS serves there are multiple and competing criteria. Even so, he judges it relatively successful in 'universalising the adequate' at reasonable cost and distributing health resources equitably.[143] As to the 'dismal new world' of the 1970s, only one innovation emerges as a clear success story.[144] This was the RAWP, which by the time of its abolition on the eve of the internal market, had narrowed the resource gap between more and less prosperous regions.[145] Evaluations are consequently favourable, with Mays and Bevan lauding 'a signal success in public policy', though Welshman is more diffident, regarding it as a product of the technocratic era.[146]

A surprising aspect of evaluations of the post-1979 reforms is just how little evidence there is of beneficial change from all the upheavals. An early assessment of the internal market by the broadly sympathetic Le Grand discovered 'little actual change ... in key areas of quality, efficiency, choice, responsiveness and equity', and where progress had occurred it was impossible to disentangle the reforms from the early 1990s funding boost as causal agents.[147] Similarly, Mays *et al.*'s comprehensive review of research up to 1998 finds 'little, major, *measurable* change that could be related unequivocally to the core mechanisms of the internal market'.[148] Boyne *et al.*'s meta-analysis of the period 1979 to 2001 also inclines to an 'agnostic or nihilistic conclusion' on the impact of the new public management reforms, although they find tentative evidence for some efficiency gains (though unsustained), some improvement in responsiveness (an assertion hardly demonstrated in their text) and some decline in equity.[149] The headline statistics for New Labour look better, with rising staff numbers, PFI-driven infrastructure growth, falling waiting times and improved disease-specific mortality rates.[150] But do the

[140]Lindsey 1962, pp. viii–ix.
[141]Lindsey 1962, pp. 454, 462, 472.
[142]Webster 2002, p. 258; Webster 1988, pp. 397–9; Webster 1996, pp. 774–7, at p. 777; Webster 1998*a*, p. 12.
[143]Klein 1989, ch. 5.
[144]Widgery 1979, p. xvii.
[145]Butler 1992, p. 37; Webster 2002, pp. 84–7; Webster 1988, pp. 389, 397–9.
[146]Mays and Bevan 1987, p. 160; Welshman in Gorsky and Sheard (eds) 2006, p. 236–8.
[147]Le Grand in Robinson and Le Grand (eds) 1993, pp. 250, 259.
[148]Mays *et al.* 2000, p. 56.
[149]Boyne *et al.* 2003, pp. 49–82, at p. 82.
[150]Giddens 2007, pp. 85–6.

structural reforms, as opposed to increased real expenditure, account for this ? Academic evaluation suggests not. Despite the efforts of policy gurus to incentivise 'knavish' producers to become 'knights', the poorly formulated doctors' contracts have forced up labour costs without commensurate productivity gains.[151] Nor does the index of NHS efficiency for the years 1995–2003 suggest that outputs were improving; indeed, productivity fell in all years except 1996 and 2000.[152]

Where do such findings from recent policy analysis leave the historian, groping towards an assessment of the reform era? Webster acerbically notes that this unconvincing balance sheet is 'rather less than the public was led to expect when the ... revolution was launched'.[153] Indeed, in his less circumspect writing, he condemns both the 1974 and 1991 reorganisations as 'mistakes' and 'gratuitous political interference'.[154] Like others, he argues that the failure of incompetently managed reforms is then taken as further evidence for the NHS's inherent problems, to be addressed by yet more destructive interventions.[155] If this is policy-making by adaptive learning, then perhaps a phase of 'unlearning' would be desirable![156] In response, it is argued that critics deny the counterfactual possibility that an even less effective NHS might have resulted in the absence of reform.[157] Nor, according to Timmins, is the scale of private sector contracting as yet anything like large enough to warrant Pollock's jeremiad.[158] To scholars such as Klein, Lowe and Timmins, the last 20 years of policy initiative must be treated as broadly successful even without unambiguous statistical confirmation. The achievement was to shift power to primary care providers, to introduce incentives to enhance responsiveness and to make the activities of the service more transparent and measurable than ever before.[159] Perfect policy outcomes are a chimera and flexible adaptation the best that can be hoped for.[160]

At the time of writing, then, the over-arching narrative of 'church to garage' still dominates, though with two poles of interpretation. The one is pessimistic, viewing the market-infused NHS as fundamentally inimical to the service's core ethic. The other is phlegmatic, treating the 'constant revolution' since 1989 as creative refinement which preserves the NHS's principles. How will these readings look at the seventy-fifth anniversary? Will the Blair/Milburn approach, once bedded in, be seen to have begun a new and distinct chapter? Or will the trajectory of fragmentation and privatisation continue until it entirely overturns the post-war social democratic project? For now, in summer 2008, with the worm turning again in the political and economic cycle, all this is uncertain.

With this in mind, which research areas might future historians of the NHS prioritise? While their predecessors may have recounted its national political history, much remains

[151] Giddens 2007, p. 86; Le Grand 2003; Paton 2006.
[152] ONS 2004, p. 2.
[153] Webster 2002, p. 204.
[154] Webster 1998*b*, pp. 26, 27.
[155] Webster 2002, p. 254; Pollock 2004, p. viii. For a psychoanalytic reading of this process, see Fotaki 2006.
[156] Fotaki 2007.
[157] Timmins 2007, p. 333.
[158] Timmins 2007, p. 335.
[159] *Ibid.*; Lowe 2005, pp. 356–8.
[160] Klein in Oliver (ed.) 2005, p. 152.

to be learned of how policy translated into practice. Here the regional study offers rich possibilities for interrogating some of the themes discussed above, such as the balance of power between clinicians and managers, the resourcing struggles between teaching, general and psychiatric hospitals, the changing fortunes of public health, and so on. The pre-1979 period, now so prone to either idealisation or condemnation, particularly deserves attention. Another promising area, not touched on hitherto, is the cultural history of the NHS. Media representations of medicine and health have until recently been a peripheral theme, though a strong case can be made for their centrality in shaping public perceptions and, by extension, political expectations of health services.[161] Now, though, a more secure theoretical foundation for the analysis of visual sources in medicine is being laid, and studies such as those by Berridge and Loughlin demonstrate the potential of the approach.[162] More prosaically, the time is also ripe to develop the economic history of the NHS. Much statistical data gathered at regional level await collection and analysis, particularly for the early period. The shifting boundary between the public and private sector in the NHS, now so prominent and controversial in the policy literature, also cries out for a full historical survey. The questions of equity and efficiency which such studies might address are, as indicated above, central to the appraisal of the service. This prompts a final observation, and exhortation. With several of the NHS's leading historians now in the latter stages of distinguished careers, it is imperative that others come forward to engage with this subject. If not, institutional memory will remain weak and the tendency to glib caricature will surely intensify.[163]

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[161] Karpf 1988; Crayford *et al.* 1997; King and Watson 2001.

[162] Loughlin 2000; Loughlin 2005; Berridge and Loughlin 2005.

[163] Berridge 2008.

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