

The UK National Health Service: Demands, responsibilities and the reconceptualization of citizenship

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A key part of the Beveridge reforms in 1948, which formed the UK welfare state, was the notion that it was the duty of government to secure the well-being of the population. This has developed over the years to the parallel idea that it is a civil right of the population to be provided with good quality health care. It is this, it is argued (together with an aging and increasingly dependent population), which has created increasing demands upon the National Health Service (NHS). However, it is now recognized that it is impossible to institute a “right to health”. Health is a biological concept, outside of the realm of direct health policy. As Foucault argues:

Health – good health – cannot derive from a right; good or bad health, however crude or subtle the criteria used, are facts – physical states and mental states.¹⁹

This means that health can only be an indirect aspect of citizenship. National governments can, at best, provide the conditions – such as medical staffing, hospital

systems, sanitary infrastructure etc – that put different sections of the community on a more or less equal footing with regard to their chances for health. However, national governments cannot guarantee the health of the population. The conceptualization of health is also problematic. Knowles argues that health is not an absolute or determinate concept but essentially indeterminate, relative and elastic.⁸ As a consequence, even if all known disease were to be eradicated, one would still not have achieved an absolute concept of health. With each new service provision, technological advance or development in medical knowledge, the very concept of health widens and extends. One could argue that the concept of health has recently expanded to include the right of women to have children (IVF and advances in reproductive technologies); the right of men to have an erection (Viagra); and the right not to be unhappy (Prozac).^{10,40} Even death can be perceived as a form of pathology rather than a natural event.⁵ As a consequence, health policy will always fail to meet public expectations of it.³⁰ This is

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not a new phenomenon. It became evident to liberal thinkers of the 19th century that the actions of the state could serve to frustrate the ends of the state itself – as intervention led to a distortion of the territory to be governed.^{3, 18}

The UK government has responded to this in a number of ways, including increased finance. However, two particular responses regarding responsible citizenship are the focus of discussion here. The first response is emphasizing citizens' role in promoting and maintaining their own health. The New Public Health (NPH) has been a key vehicle in this response. The second response introduces service modernization to shift power in the NHS from professionals and to consumers. Through these two policy responses the Government hopes to shift more responsibility for health onto the shoulders of the public.

The New Public Health

The NPH approach focuses on identifying and tackling factors that underlie the causes of illness – the upstream factors. While this is an important part of any public health model, the upstream factors being identified are less the structural inequalities of society and more the action of individuals. In an increasing number of UK government initiatives, concerns about the structural causes of ill health have been replaced by a focus upon individual action and upon individual's social capital (CF. Social Action Research Project (SARP), Health Action Zones (HAZ)). People are being encouraged to rely more upon themselves. A key feature of this argument is that the NPH (including health promo-

tion) is adopting a neo-liberal approach to achieve its *own* objectives, particularly when faced with the fiscal concerns of increasing demands upon health services.³² This ideology is trying to break the link in public perception between provision of services and demands for health improvement. The value of access to services is being replaced with a new preoccupation with controlling at risk behaviors. Despite the language of empowerment, the agenda of NPH still reflects government objectives laid out by professional experts.³² The NPH can be regarded as a moral enterprise, promoting prescriptions for how we should live our lives. This is politicization of the self, through discourses of empowerment.^{32, 34}

The role of health promotion is therefore at the epicenter of the NPH movement. It is the vehicle by which government concerns are transported throughout the social network to arrive at the level of agency. By defining risks and consequent strategies for risk avoidance, health promotion attempts to change the behavior of individuals. It is assumed that when presented with the facts, social agents will become active participants in the process of risk prevention.³²

At a time of increasing demands, self-discipline has emerged as a popular theme. Instead of rights and entitlements, individual responsibility and self-help have moved to the center of political discussion. By normalizing certain patterns of behavior, health achieved through self-control and good citizenship is assumed to be a priority for all.⁸ The politicization of NPH within Europe is signalling a new politics of citizenship, with greater emphasis upon the duties, which are implied by rights.^{10, 33}

Now, as social citizens, we are expected to be self-regulators of our actions and bodies.^{7,25,28} As a part of this process, collective rights to welfare are being replaced by individual obligations.²⁸

The calculation of risk by social agents is a central tenant of NPH. In this sense the onset of preventable disease or illness can be regarded as a personal failure.^{4,22} This notion of the “Individual as Enterprise” also has the implication that the body is becoming a site of moral worth and that illness may bring the potential for blame with it.^{9,22,31}

Individuals whose conduct is deemed contrary to the pursuit of a “risk-free” existence are likely to be seen, and to see themselves, as lacking self-control, and therefore not fulfilling their duties as fully autonomous, responsible citizens.³¹

Beck and Beck-Gernsheim link the shift towards personal responsibility with changes in employment:

To keep one’s head above the water in a competitive labor market it is necessary to be fit, healthy and capable. Now, health is not as much a gift from God, as a task and achievement of the responsible citizen, who must protect and look after it or face the consequences...health used to be something given to us that only required repair in an emergency, now it has to be constantly produced.⁵

This notion of good citizenship incorporates the concept of “fluid subjectivity” where power and knowledge are internal-

ized through a process of self-surveillance.¹ This adherence to changing social norms creates a form of ontological security. More specifically, the concept of risk prevention is constructed as real.³⁵ In part this may become manifest through the use of stigma to reinforce the anti-risk social norms in those not conforming to them. Health promotion can play a part in this by defining moral principles for healthy behavior and by delineating moral judgements and stigma for deviation from them.⁹

Responsibility is presented as meaning greater autonomy, however... anyone who does not take responsibility is counted as irresponsible... The health system would increasingly assume the role of institutionalized monitor of peoples lifestyles.⁵

The phenomenon of “healthism” basically refers to the pursuit of being healthy and succinctly illustrates the impact of health promotion in the defining of moral values. Health promotion strategies provide social agents with information regarding what constitutes healthy behavior. It then becomes the individuals’ choice as to whether they prevent disease or not. The consequence of this is that when people do not conform to regulating their behavior it can be viewed as “a failure of the self to take care of itself.”²² To assist in this, food agencies etc are being increasingly challenged to display full information on the content of their products. In addition, the UK Government is said to be considering a “Fat Tax” on foods with particularly high fat content in an effort to combat obesity (BBC National News 2004, 20th February).

Health and Social Order

The rise of individualization linked to the politicization of NPH illustrates the changing relationship of health and the role of health promotion, in the social order. The UK policy document “Our Healthier Nation” (1999) stated that health was dependent upon “a new three-way partnership, comprising individuals, communities and government.”¹⁶ It is interesting to note that the subtitle of *Our Healthier Nation* is a contract for health. Contracts place mutual obligations upon the parties involved. This is indicative of the principle of responsibility, which works as an increasing force throughout the health care system. This illustrates an example in the UK where NPH is operating at the level of both structure and individual agency. By offering advice (risk discourse) to the population at large, health promotion is defining (and promoting) a set of social values regarding health and well being.^{9,32} Strategies of risk management are distributed throughout society by a process known as intersectoral collaboration. This process does not involve direct coercion, intervention or punishment by health promoters or police makers. It refers to “a multi-levelled and multi-organizational network of surveillance and regulatory practices.”³¹ With specific reference to health promotion strategies, it illustrates the way in which they operate at a distance by encouraging the co-operation of various social groups and individuals.²

This is linked to changing notions of citizenship, which emphasizes personal responsibilities, and where risk prevention is promoted, as an active challenge for individuals.¹⁰ Governmentality applies here

where moral components to social life (in this case health policy and service access) are dependant upon the active participation of individuals in “the deployment of technologies of the self in the conduct of social policies.” One consequence is that people may be refused NHS operations because they are engaging in at-risk behavior – i.e., they are overweight, smoke, etc.

The new citizen learns to engage with risks constructively because, if he or she doesn't, there is no collective security net waiting to make good the damage.²⁵

Health has therefore become conceptualized as a core social value within society where the individual's relationship with health is being governed by notions of civic duty.^{8,24} Public health and government, in seeking to change individual risk behaviors, may also need to bring about changes in the social contexts that influence why and how people behave in certain ways.⁹ Preventing the spread of infectious disease is known to involve the power of government and community in ordering and controlling the lives of individuals for the public good. In a similar way, health promotion seeks to control individual behavior for the individual's good and to benefit society. When individuals resist public health campaigns (wearing crash helmets on motorbikes) the state steps in with legislation. The state also intervenes by means of financial disincentives to action, such as the taxation regime on alcohol and tobacco. However, such control is always a mutual affair.³⁷ Thus the NPH movement can be regarded as a mechanism for social order as it depends upon social,

as well as, individual action. Suppressing undesirable individual behavior, such as unhealthy lifestyle choices, and replacing them with desirable behavior is largely an issue of social control.³⁷ An example of this can be found in the government document “Our Healthier Nation” which states that “everyone in the country is affected by this program and we have to do our best to make sure that everyone is committed to it. That’s the only way we can get things done – saving lives, improving health and reducing inequalities.”¹⁶

Social roles and expectations combine to effectively make up the social system. Social roles can be interpreted as social duties, which are for the benefit of the wider society. “Social control involves both the maintenance of a moral community and the collective initiation of intentional, purposeful change.”³⁷ To be effective, social roles also requires “a high degree of correspondence between personal motives and group goals.”³⁷

However, this approach threatens the earlier aim of health policy, which was trying to equalize health options.⁴² The risk management model of health provision is fundamentally not redistributive, in the sense that redistribution is seen as overly deterministic. Giarni and Stahel argue that modern societal and economic development depends not so much on achieving perfect objectives, but rather upon developing creative activities in a world where uncertainty and risk are a given condition.²¹ The implication is that individual creativity in the provision of personal welfare (including health) is the ideal form of social insurance. This is an underlying tenet of the Government’s “middle way” policy programs.³⁸ The Government’s postulation

for a health service based upon the recognition and management of risk carries the subtext that risk, in some sense, can still be known. We can not predict, however, what will be risky in the future (as eating beef would not have been considered in any degree risky 10 years ago) and thus people can not design their own risk-aware life politics to a sufficient degree. It is argued that the State sees its prime role for the future here.¹⁷

Service Modernization

Within the UK, and indeed much of Europe, the ongoing process of modernization in health services has involved the introduction of arrangements that are characteristic of late modernity. This is evident at a number of levels in health policy and health care. For example, The Audit Commission conducts value for money audits of all health care services. The Healthcare Commission (HC) regularly and routinely inspects National Health Service Trusts and can investigate into areas of inadequacy. In addition, there are performance assessment frameworks that necessitate the regular collection and reporting of data against set performance indicators. This forms a mechanism for surveillance and accountability against centrally defined criteria. All this is necessary to ensure that service provider organizations are performing against nationally set performance targets and other service quality assurance indicators.

All this and other information have recently been brought together to form star ratings for NHS service provider “Trusts.” At the moment three stars are the maxi-

mum that can be awarded, though this is intended to move to “performance +” stars over the next few years. These will effectively form a league table where performance of trusts can be compared and rewards and penalties administered. The aim is clearly surveillance and “sticks and carrots” to drive up the quality of service and organizational performance.

The concerns about poor organizational performance within the UK have, in a large part, been driven by national scandals surrounding medical practice. High profile cases include poor quality in children’s heart surgery, and deceased children’s organ retention.^{12,13} There have also been high profile cases of adverse drug reactions, erroneous prescribing and increasing numbers of patient complaints.¹⁵ The infamous Harold Shipman case was another, with estimates of killing up to 215 of his patients over his professional career (Guardian Newspaper July 20th 2002). The subsequent enquiry and its aftermath also fundamentally shook the public’s trust in General Practitioners (GPs) and led to calls for their accountability to be strengthened. Certainly there was a deep suspicion of GPs immediately post-Shipman with each Primary Care Trust instigating enquiries into concerns over the activities of individual GPs, which subsequently turned out to be groundless (Guardian Newspaper June 5th 2001).

It is worth recounting the stories reported in *The Times* newspaper (arguably the newspaper with the highest standing for journalistic integrity in the UK) from February 2004. On February 1st there was a major story on the cover up of sex abuse by doctors, who as a profession reportedly faced 1,500 complaints last year from pa-

tients who alleged that they were sexually or indecently assaulted. Figures from the UK General Medical Council show that 85 doctors were convicted of sexual misconduct over the last year, a figure that has quadrupled over the last four years. The *Times* then went on to outline the details of some of these cases. On February 2nd there was a report marking the death of Ernest Hendon, the last survivor of the infamous Tuskegee syphilis trials in the USA, which detailed the 40-year medical experiment and his unwitting role in it. On February 3rd there was a report on medication errors due to doctors’ excessive work loads. Prescribing errors were described as an enormous problem within primary care. Finally, on February 4th there is a report of a coroners inquest on a woman who died whilst having a hysterectomy because of a gross failure by a relatively junior doctor to recognize obvious symptoms of internal bleeding. All national and most local newspapers, now have dedicated health correspondents whose role is to inform the public on any such developments within the health service.

It is hardly surprising that these national scandals and continuing reports of medical failures have impacted the trust that the public has in its medical practitioners and in the NHS. The governments response has been to improve institutional oversight by means of the National Clinical Assessment Authority.²⁹ In order to improve the quality of practice, all doctors were statutorily obliged to with appraisals and undertake a system of revalidation through the General Medical Council.²⁰ In addition, a new body was established to co-ordinate and oversee the work of individual professional organizations responsible for standards in

practice – the Council for the Regulation of Health Care Professionals.¹⁵ The practice of all health professionals is now heavily monitored.

An inherent presumption in modernization reform is that reliable knowledge is obtained from cumulative research based on scientific criteria. Harrison refers to health care delivered from this epistemological perspective as scientific-bureaucratic medicine and differentiates it from care that is informed by reflective practice, professional consensus and practitioners critical appraisal of research.²³ The focus is upon ensuring that the public can have the confidence that appropriate systems of regulation and quality assurance are in place. Service user empowerment, consumerism, complaint procedures and other elements of modernization involve users in surveillance of practitioners, planning and service provision.³⁶ This includes plans for users to have a choice of up to five service providers for each possible intervention from April 2005; one must be from the independent sector. Such arrangements attempt to translate the insecurity, associated with uncertainty, into relative security afforded by calculative and predictive techniques.⁶

Modernization in the NHS is, of course, not just about regulating and scrutinizing the activity of medical professionals. It is fundamentally also about being responsive to patient needs. Doctors, nurses, other professionals and even managers (though valued) were seen to be part of a culture that was highly resistant to change. The path towards modernization was to change medical culture by involving the public, as much as possible, in the running and evaluation of services. Legislation to involve the public in the NHS's work followed.

The NHS Plan, released in July of 2000, was one such piece of legislation.

The NHS of the 21st century must be responsive to the needs of different groups and individuals within society and challenge discrimination on grounds of age, gender, ethnicity, religion, disability and sexuality. The NHS will treat patients as individuals with respect for their dignity. Patients and citizens will have a greater say in the NHS and the provision of services will be centered upon peoples' needs.¹¹

The NHS Plan was the vanguard of a series of policies aimed at creating a new culture in the NHS at all levels, which puts the patient first.¹¹ Chapter 10 of that plan included a section on information to empower patients and also unveiled its "Expert Patients Programme." Service and individual performance information will be made available on the Internet and patients will be able to use this information to choose their GP. They are also to have more choice in where a referral is made and starting in 2005 they will be able to book the time and date of hospital treatments themselves. This itself has an impact upon doctors' professional self-image and there has been resistance.³⁹ Those in the medical profession do not want the principle of caveat emptor to apply to them. They do not want the client to make an individual judgement upon the competence of practitioners or the quality of service. The interaction between professional and client is such that the professionals strive to keep all serious judgements about competence within the circle of recognized colleagues.²⁶

Thus the public is protected from its own incompetence, from its own impossible demands and the quacks that might exploit them will not be allowed to practice. Wilson discussed the traditional notion of the doctor patient role – the physician as expert and the patient as amateur:

Possession of the initiative and of recognized competence imply power, they also imply a correlatively heavy burden of responsibility. Although the patient too has important obligations – especially the central one expressed by parsons as “to try to get well” – it is the practitioner who must act. He is hourly engaged in what is probably the most difficult of human tasks – decision making – and in a setting where the consequences of error are quite often irreversible and very dangerous. Entrusted with the most precious of assets, the living body and mind, the practitioner must chart a course of therapy... All practitioners are professionals and all patients are amateurs.⁴³

Contrast this view with current UK government policy on the expert patient. The Expert patient – a new approach to chronic disease management for the 21st Century, was published by the Department of Health in September. This policy document set out how the Expert Patients Programme would aim to empower those living with chronic long-term health conditions to become key decision-makers in their own care. It initiated action, over a six-year period (2001-07), to embed in the National Health Service lay-led self-management training programs for patients


with chronic conditions. Earlier research by Macintyre and Oldman have relevance to this program. They also pointed to change in power relationships that the EPP is concerned with:

In claiming that we have become experts in the handling of our migraines we are suggesting that while our knowledge may be gleaned largely from medical sources it is superior to that of individual doctors. This leads to important consequences for the relationship between patient and doctor... While the sufferer may feel his own knowledge to be superior to that of his doctor, the latter may well feel his knowledge to be superior in being more scientific and abstracted from imprecise accounts of many case histories. Our assumed expertise is also a challenge to the doctors' role and his authority of expertise.²⁷

This illustrates that the EPP may be formalizing relationships that have existed for some time rather than being necessarily revolutionary in concept.

Conclusion

In response to rising demands for health and higher quality in health services, the government has sought to shift the emphasis onto the general public. This will undoubtedly increase the responsiveness of health services to public needs. However, it has done so by evoking relatively new strategies of governance in the UK, including strong regulation of professional activity. This was made possible because

of a period of diminution of public trust in medical practitioners. It is far too early as yet to tell if these policies will be successful, however, early indications are that Government has been able to engage with the public in the UK in moving in the desired direction. 

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