The problem of health care is 'infinite demand and finite resources'. We need a big rethink.

Steve Iliffe

Health Care a headache for the Left

The Health Service is in crisis. Pickets across hospital gates parade it, and ministers, real and shadow, proclaim it. Our newspapers reflect the conflicts between government, strikers and public need in headlines, pictures and text. Scenes of unprecedented conflict fill TV bulletins: police vans doubling as ambulances; uniformed nurses beneath union banners; elegant teaching hospital specialists eyeball-to-eyeball with porters and cleaners; Health Authority chairmen challenging the government — and getting the sack. There is something peculiarly British about this battle within the state. We are now so used to conflicts within the apparatus of health care, and so aware that similar problems do not (often) appear in France, West Germany or Scandinavia, that we can believe that our health care crisis is as unique as our health service.

The belief is false. At its most erroneous, it assumes that Conservatism is the origin of the crisis. A hawkish government ideologically hostile to state industry in all its forms, aims to dismantle the NHS and making the working population suffer. Replace Thatcher (or her successor) with Foot (or his), and the NHS could easily be retained, and rapidly expanded, without conflict or contradiction.

A sharper criticism selects monetarism as the problem, and an expansionary economic policy as the solution. Replace the monetarists, whether Tory or Labour, with Keynesian politicians, and the health crisis will recede. Money diverted from defence, from private profits, from the super-rich, and from newly nationalised industries will solve the problems of low pay, under-staffing, unequal distribution of resources and ancient facilities. Under a Left government the National Health Service would thrive again. Or would it?

A structural crisis

Not for long, I think. In the short term the alternative economic strategy might permit dramatic expansion in health care. In the longer term, even if the national economy recovers from its current state, the structural crisis of health care is likely to continue. This 'crisis' is common to West Europe, the USA and Scandinavia, and there is evidence that it is also a growing feature in Central and East Europe, and in the USSR. In essence, it is a crisis of over-consumption, best described in the West by the Right, with the slogan 'infinite demand, finite resources', and in Eastern Europe by the idea of 'the suction economy'. The common theme in these contrasting perspectives is that demand exceeds supply, and that available resources are hoovered up by consumers regardless of the objective need for them. In health care this appears as increasing consumption of drugs, increasing expenditure on high-technology services, increasing staffing levels, and an increasing proportion of GNP devoted to health services.

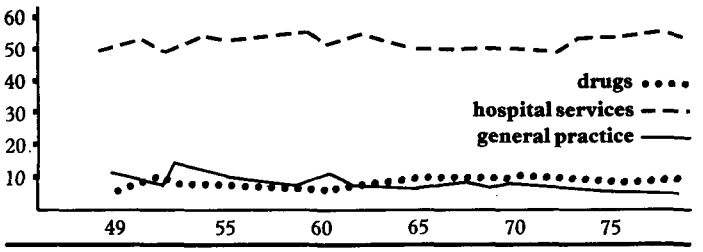
The output in terms of better health from all this activity is not impressive, unless the avoidance of unemployment is considered. Qualitative improvements in the duration and quality of life are achieved, but they are often difficult to measure convincingly, and all too frequently, small-scale. Enormous efforts are needed for a low yield. The medicalisation of life, that turns pregnancy into pathology, that converts the poverty of old age into vitamin-deficiency states correctable by tablet, and that smooths away deprivation with tranquillizers, is one component of the crisis. A preoccupation with well-equipped hospitals, functioning round the clock as grossly-inefficient but very necessary salvage centres is a logical consequence of medicalisation. And the creation of expertise, which becomes more and more specialised and limited in scope as technology develops, completes the process.

If the problem is that some babies are born far too soon, then the answer must surely be: more special nurseries (with their incubators and respirators); more specially-trained nurses, doctors and technicians to look after them; and more studies of how these babies fare in later life, to see if it is all worthwhile. Common sense (made from sectional professional interests, the anxious wants of health service users, and the profitable ambitions of drug and hospital supply industries) carry us all down this road — providing the best service possible for The People. That's progress.

Rising pattern of expenditure

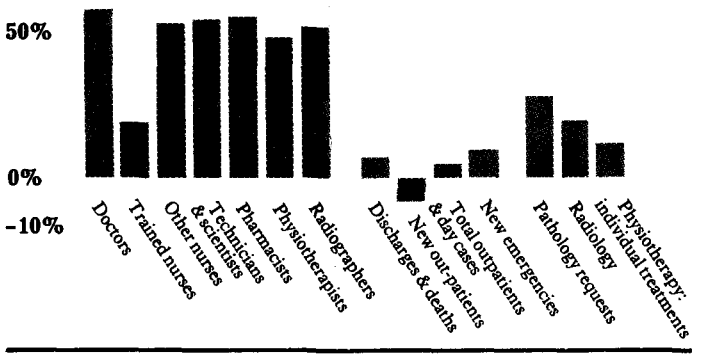
Unfortunately, it can't last. Demand for health care may not be infinite, but as yet we have no experience of its limits. Expenditure on health services in Britain as a proportion of the GDP, has steadily risen since the mid-50s. An increasing share of this expenditure has been taken by the hospitals, with a decrease in the proportion used by general practice (Figure 1). There is little evidence to show that increased expenditure has altered important indices of health. 'Productivity', in terms of increased numbers of patients discharged from hospital, or seen for the first time in outpatient clinics, has not

Figure 1 **Spending on hospital services, drugs and general practice, as a percentage of total NHS spending, 1949-78**



Source: Royal Commission on the National Health Service, 1979.

Figure 2 **Percentage increases in hospital services 1971-77**



Source: *Crisis in the Health Service*, Haywood & Alaszewski, 1980.

Figure 3 **Public & private sources of finance for health care, 1975**

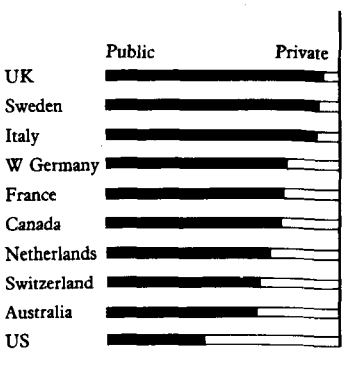
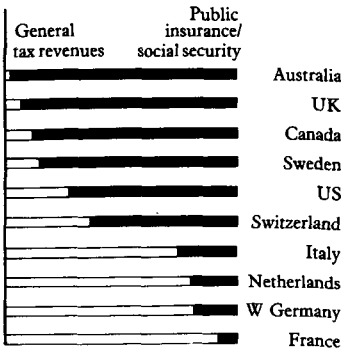


Figure 4 **Composition of public health care spending 1975**



increased proportionately to increased use of technology or increased staff deployment (Figure 2). Expansion in staff numbers in the NHS has been dramatic but capital expenditure on new facilities has been much more limited. The end result is an under-capitalised industry deploying more and more workers to achieve disproportionately smaller growths in yield. Starting from the assumption that the volume of illness already known to health workers is only 'the tip of the iceberg' of medical problems we still find that responding to such hidden problems is increasingly expensive.

Within Western Europe, and to a lesser extent in the USA, Australia and Canada, the rising costs of health care have been met from public funds. Figure 3 shows the relative contributions of public and private funds to health care, for ten countries, in 1975. The role of general taxation sources, as opposed to state-run insurance schemes, is shown for the same countries, in Figure 4. Those who believe that Britain leads the field in public spending on health may be surprised at the ways in which other countries use state funds for their health services. Even the USA, before Reagan, was forced into spending increasing amounts of Federal and State money on public hospitals, and the Medicare and Medicaid programmes.[1]

Controlling costs

The British National Health Service is remarkable within capitalism, for two features. The first is its use of general taxation revenue as its financial resource, rather than an ear-marked tax in the shape of health insurance. The second is its centralised control structure, designed for maximum efficiency in the use of resources. A series of structural reforms, conceived in the sixties, allowed successive UK governments to spend porportionately less on health care than their W European counterparts whilst maintaining a comprehensive service equivalent to any European system.

The three-tier administrative apparatus introduced in 1974 and based on the principle of 'delegation downwards, accountability upwards', created a mechanism that, in theory, could strictly control expenditure. It was accompanied by the hierarchic rationalisation of nursing (the Salmon report 1976) to create a cadre of nurse-managers and the involvement of the medical profession in corporate decision-making through the Cogwheel system.[2] Financial changes occurred within two years. In 1976, volume spending was replaced by cash limits, under a Labour government initiative. Volume spending required central funds to cover the costs of services provided at the local District or Regional level, with scope for bargaining between centre and periphery. Cash limits abolished negotiation by allocating specified cash sums to Regions, Areas and Districts. Overspending could be dealt with by cutting overspent sums from the following year's budget — a form of borrowing with catastrophic implications. Serious cuts in services to the population followed the introduction of cash limits, particularly since government estimates of inflation tended to fall short of the real figure.

The general strategy of both Labour and Conservative governments has been the same; to create an effective controlling mechanism that can restrain and possibly redirect NHS spending. Labour administrations have favoured redirection of finance towards areas of greatest need, and have emphasised the role of planning.[3] The Conservatives have opted to look for alternative, non-governmental, sources of finance, and have therefore promoted private medicine and private health insurance.[4] Neither type of government has challenged the basic assumptions about priorities in government spending on health compared with defence.

The traditional Left response

The traditional response from the Left has been to shift spending from defence to more socially-useful areas, health included. The government rejected the proposals of the Black Report on Inequality and Health, on the grounds that they would cost £2 billion. Reduce defence spending, by removing one or two items (like Trident), and

[1] 'Medicare' & 'Medicaid' are government-funded insurance schemes for the elderly and the poor. The impact of Reagan's administration on them is discussed in 'The Reaganomics of Health' by Geoff Rayner, in *Medicine in Society* Vol 8 no1 p35.

[2] Professional re-organisation occured on much wider scale than I can describe here. A detailed review appears in Stuart Haywood and Andy Alaszewski's *Crisis in the Health Service*, Croom Helm, 1980.

[3] The Resource Allocation Working Party became imfamous for its RAWP Report, which advocated re-direction of finance from allegedly less-needy to more-needy areas. The re-allocation was initiated at a time of cash-limiting, so that some areas (particularly London) were doubly deprived of funds whilst other areas (like Tyneside) had their cuts offset by re-allocated finance.

[4] See *Going Private: the case against private medicine* from the Politics of Health Group and *Condition Critical: private medicine and the NHS* from the Communist Party.

photo Barry Lewis/Network

that money becomes available. Adopt a policy of unilateral nuclear disarmament, and more cash is freed. Withdraw BAOR and demobilise it slowly, using the spare labour in an expanding economy, and two objectives can be achieved, in one move. The economic consequences of a redefined defence status could only favour the health of the nation.

This argument seems sound, but there are two problems in it. The first problem is that opting for neutrality is a huge political gamble. The gains may be substantial, although our experience of socialism does not guarantee that. The losses could be enormous. An economic and political counter-attack from the USA or the EEC may destabilise the reforming government and jeopardise all that it promotes — from public services like health care, through control of the economy, to democracy itself. How can the Left demonstrate that the gamble of changing the economy and social structure of Britain would be worth the risk? Only, I think, by offering new solutions to the new problems of evolving capitalism. In terms of our health service, this means confronting the second problem, the structural crisis within health care itself. Far from resolving the economic strains created by health service spending, an expansionary policy may worsen them. An initial recovery in the economy, coupled with redirection of finance, may give a short-term boost to health care spending. Will the NHS growth initiated in the 'boost' period continue even if economic growth slows down again? On past evidence, it will. If it does, how can a government committed to social care reduce spending on health services?

There is one sense in which the long-term structural problems of health care are more important to us than the immediate economic problems of underfinancing, cash-limits and low pay within the NHS. We have some ideas, from the socialist countries' experiences, of how to solve the economic problems through economic planning. We have little help, however, in dealing with structural problems, which seem to apply across the board. None of the countries of the socialist bloc seem to have come to terms with them yet, and there is no reserve of experience to use. In fact, sustained economic growth in socialist Europe seems to have postponed the impact of the more serious structural problems, whilst not eradicating the factors causing them. What Britain, Italy and the FDR experienced with their health care systems in the 70s appear to be prospects for the GDR, Hungary and possibly the USSR in the 80s.

The basic causes

If we look at the structural problems of health care in detail we can see how novel they are. Firstly, neither users nor suppliers of health care are responsible for its costs. When individuals pay directly and personally for health services, cost determines uptake. When demand (sometimes disguised as 'need') is allowed to determine uptake, in a service free at the time of use, a third party pays for whatever transpires. That third party may be the state's general taxation or a state-owned, or state-licenced, insurance system. When third parties meet the bill, neither health service users nor professional suppliers are concerned primarily with cost-benefits. Users do not 'shop around' wisely, because they are not acting as consumers of commodities, but in reality want problems solved, whatever the price. Providers do not generally ration their services on economic grounds, partly because they see solutions to problems in terms of

how can a government committed to social care reduce spending on health services?

the application of medical technology (drugs, tests, operations), and partly because they may be paid on a piecework basis.[5] Extension of third-party payment for health care to whole populations is a post-war phenomenon in both socialist and capitalist Europe.

Secondly, the equation 'health care = medical care' may be valid (up to a point) at a personal level, but it has unhappy consequences at a social level. Governments actively seeking to meet the needs of their people (like the 1945-50 administration, and socialist governments) have had to assume that health care is a technical task, with medical professionals as its most skilled technicians. In effect, technical experts have been given the right, within the principle of equal access to services, to determine not only how the service is provided, but how its goals are defined.

If heart disease in middle aged men becomes an epidemic killer, the answer, defined by the experts within their expertise, is more money for coronary care units, more cardiologists, more open-heart-surgery — even if the origin of the epidemic lies in social conditions of work and consumption. If lung cancer is a growing problem more cancer-specialists are needed. Control of tobacco consumption is outside the sphere of medical expertise, which sees itself as responding to individual problems created elsewhere. The logic is inescapable. Men and women with heart disease or lung cancer desperately need help. The more of them there are, the more help and helpers are needed. No government in a highly industrialised country can ignore these problems, and refuse to contribute in some way to their solution.

The consequence is the development of networks of hospitals filled with expensively-trained specialists and equally expensive machinery. Even where some kind of low-technology first-line of health service is retained, like Britain's general practitioners, the trend in spending constantly favours hospital-centred services. This will create enormous problems for a new kind of Labour government, for it will have to distinguish between essential spending on hospitals — to replace the one-third of hospital floor space built before 1900, or to restore cut services — and the pressure for more and more expenditure in response to increasing demand.

The socialist countries

Socialist countries are becoming familiar with this problem too. In the GDR 6% of the population are employed in health and personal social services, (compared with less than 3% in Britain) and the Government's emphasis is now on increasing the efficiency of the health service through 'better'management — almost exactly the managerial strategy applied (without much success) in Britain in the 70s.[6] In Poland, Gierek's government introduced a National Health Fund for voluntary subscriptions, to increase the budget for health care.[7] The Hungarian health service deploys twice as many doctors per thousand population as Britain, and has a 25% larger workforce than the NHS but pay rates for health workers are lower than NHS rates, relative to GDP. Officially about 4% of Hungary's GDP is spent on health care, compared with 5.5% in the UK in 1980, but the Hungarian figure (unlike the British) excludes private medicine, prescription and other charges to patients, and medicines bought directly from chemists. One estimate puts the cost of Hungarian health care nearer 6% of GDP.[8] The socialist economies can bear, and may benefit from, large health services. There is little sign, though, that these services can escape from hospital-centred medicine and escalating costs. The mechanisms of control adopted by governments are remarkably familiar — centralised management, low pay for health workers, and alternative sources of finance through private medicine and charges to patients.

Finally, low-technology first-line services ('primary care' in jargon) can change sign, from being a barrier to expensive hospital-centred services to being a further area of costly expansion. Since 1948 British general practitioner services (doctors, dentists, pharmacists and opticians) have been used as a screen between the population and the hospital network. This screen has proved cheap to run, because like the hospital sector it has been undercapitalised. General practitioners provide their own premises, in the majority of cases, and receive subsidies for staff and buildings in return. Only 17% of GPs were working from health centres in 1980. Unlike the hospital sector, staffing levels have not risen dramatically. Governments aiming to reduce health care spending have always been careful to keep primary care just ticking over.

If, however, a Government chooses to expand the primary care system, either to further reduce access to hospital services, or to put more emhasis on preventive medicine, it must face the economic consequences. Primary care services, if properly constituted, are as expensive as hospital services, but for different reasons. For example, the capital cost of creating enough health centres to accommodate *half* of Britain's GPs in very basic, small-scale units, would be about £5000 million at 1979-80 prices. That is not much by NHS standards, but those health centres would be valueless without their staff, and staff expansion — to include more administrative staff, nurses, health visitors, dieticians, remedial therapists and psychologists as well as doctors — would be the major cost in primary care renewal. Any realistic shift to preventive medical care will demand increased contact time between people using the service and the workers providing it, and so would increase staffing levels even further. Whilst this may contribute to economic revival by creating jobs, it would still add to the costs of health care.

What kind of solution?

A government which opts to re-expand the NHS primarily by expanding its first-line services will have to find ways of limiting expenditure on hospital medicine. Like it or not, cost-control mechanisms will be needed, even within an expanding NHS budget. Traditional mechanisms aim either to discourage users by charging them directly (with prescription fees, dental charges and so on) or to limit availability and make people queue. Health service users also have traditional mechanisms for by-passing rationing; the most obvious one is the simple expedient of paying directly and personally for individual attention. How would a reforming government cope with the ideological challenge of rationing a 'comprehensive and freely-available' service? And what could it do to prevent the development of a parallel, private, system of health care? Worse still, what if the shift to primary care and preventive medicine proved to be as ineffective in altering people's health as hospital-centred medicine has been? What if the uptake of the expanded primary care services also expanded dramatically — would these services have to be rationed, too?

These structural problems in health care leave us guessing, at the moment. A government led by Jenkins and Owen, or Healey and Shore, would opt for conservative solutions of cash limits and service cuts for lack of any other. There is a great need for realistic alternative strategies, and for the groundwork that will

photo: Ann Silverleaf

[5] Most doctors in Britain are salaried employees of the NHS. However, all general practitioners (medical, dental, pharmacy and optical) are independent contractors to the NHS. They derive part of their income from fees for particular items of service that they perform. For example, GP doctors are paid for each cervical smear test done for a woman over 35 (or with more than three children), each child immunised, each contraceptive coil fitted and so on. Roughly one third of GP doctor's income comes from such fees. In capitalist Europe this 'fee for item-of-service' payment is more widespread than it is here.

[6] The theme of the GDR delegates to the International Conference on the Political Economy of Health in West Europe, held in Frankfurt in July 1982.

[7] See 'The Health of the Polish Health Service' by Frances Millard in *Critique* 15

[8] See Mark McCarthy's article in *The Health Services*, Friday July 9th 1982

allow their implementation. It would be untrue to say that there has been much progress, in alternative ideas or in alternative practice. On the contrary, traditional socialist thinking has incorporated 'technical rationality' in health care — the expert knows best. Solutions posed as alternatives, like self-help, or fringe-medicine, or 'natural' approaches (whether to health foods or to childbirth) are consumer responses fitted more for the market place than for social provision. Perhaps the movement for reform of maternity care, and more certainly, the campaign for women to control their fertility, challenge 'technical rationality' and provide us with models for action.

Whatever the models, we do need to replace expert control of decision-making in health by social control. As a minimum, that demands both public debate about priorities in health care and public control of health care administration. That is only a necessary precondition for social control, however, since our only experience is of technical rationality and our perspective is thoroughly medicalised. The prospect of a publicly controlled NHS meeting a widespread demand for say, 'check-ups' of no proven value at great expense, is not a satisfactory answer to the crisis in health care.

Need and demand

In health care 'demand' has determined the provision of services, not 'need'. 'Demand' is a market concept that is inapplicable to health care unless that care is provided on a market basis, through private medicine. 'Need' is a concept that assumes an objective state that can be measured and acted upon. It assumes that a mutual agreement can be reached between user and supplier to define a given problem one way, not another, and to act on it in one way, not another. For example, a headache may be evidence of a brain tumour to its sufferer, but of migraine or tension or some other cause to the supplier of medical care. The 'demand' may be for X-rays, brain scans and the attention of a brain surgeon. The 'need', however, is to work out the most likely cause and act upon it. In health care the concept of 'need' has a place since technical experts are thought to distinguish the 'need' within the 'demands'. We know that health professionals only make such distinctions at a basic level, by diagnosing and treating illness in individuals who demand attention. If there is no demand, then no need is perceived. Hence the enormous variations in the services used by people, across Britain, and across classes.

At the same time, the selection of the 'need' within the 'demand' depends on the selector's own bias. Brain surgeons, confronted with headaches, look for brain tumours with all the diagnostic equipment available. (If it is not available they agitate until it is.) Psychiatrists, on the other hand, will search for sources of anxiety or depression behind the headaches that they encounter. Brain surgeons finding no tumours may call on psychiatrists for help, and worried psychiatrists anxious not to miss physical diseases will use the services of brain surgeons. Both will soon become overworked, and demand more staff. Once in motion, the machinery of health care expands. Assessing its value, its effectiveness in solving people's problems, takes second place to efficient management of the mechanism. After all, the expert knows best, and if they want a bigger machine, that must be the right policy.

A government pledged to renew the NHS will have a difficult task. It must attend to the unmet need, and try to correct class inequalities in health care. It must also try to limit the activities of the supplier of health care, who will promote continuous expansion unless checked. How can it achieve both objectives? How can priorities be agreed and enforced? Can the contradictions be resolved by the Left's usual solution — democratic debate? Public debates on 'needs' and on their priority for action, will certainly take health policies out of expert hands and into political life. That will cause conflicts, of course. Experts created in the mould of 'technical rationality' will not readily give up their power over decision-making. Nor will drug and surgical supply industries that rely on experts' priorities for their profits accept a shift to social control. Local interests may clash with agreed priorities of need, with endless scope for conflicts with administrative structures. This is unfamiliar and dangerous territory for the Left, but well-known to the pragmatists and opportunists of the Right. Sadly despite a wealth of experience of planning, participatory democracy and the contradictions that develop within public administrations, available from 1917 onwards, we remain remarkably ignorant of the *real* problems of social control. The utopian socialism of Labour's Left (and the ultra-left) now thrives because a one-dimensional, propagandist faith has so greatly weakened mainstream Marxism.

Beyond slogans

The acceptance of economic reality in health care will be an unpleasant task for the Left, but very necessary. We cannot afford to assume that demand constrains the health care economy. It seems to be the opposite — the supplier determines economic change. Controlling the suppliers — drug and hospital equipment industries, and the professions themselves — is going to be a government priority. That inevitably leads to other problems: the relative run-down of industries that may be significant in the national economy; tight control over professional activity that can only provoke resistance and political conflict; and possibly rationing of health service provision. The pharmaceutical industry may be a potent contributor to export-earnings, and a major employer, even if only through its packing sub-industry (as in Britain). Professionals — particularly doctors — are by definition hostile to control and direction. How to plan distribution of professional staff, to direct professional labour to areas of greatest need, and to minimise or prevent altogether the growth of private medicine 'on the side', are questions barely considered in the Labour Party and the Left. Yet professional power is manifest, from its impact on the use of resources in the NHS, to the overthrow of the Allende government in Chile in 1973.[9] Rationing provokes resentment, queue-jumping by bribery, and a 'black economy' of private medicine — yet it may be a necessary and permanent feature of health care provision.

Brain surgeons, confronted with headaches, look for brain tumors with all the diagnostic equipment available

It is easy to produce the slogans: 'defend and extend the NHS'; 'restore the cuts'; 'abolish prescription charges'; 'ban private medicine'. The problems, however, are the problems of the 80s. The slogans leave the problems untouched. How much could a working class in power *really* achieve? What are the realistic goals for the Left? Perhaps answering these questions for health care — or housing policy, or education, or re-industrialisation, or any other basic issue — will allow us to answer the fundamental question: how to achieve revolutionary change? □

[9] See Geoffrey Hamilton's 'Professionalism: lessons from Chile' part 1 in *Medicine in Society* Vol 7 no2, 3, part 2 in Vol 7 no4.

Peter Hain

Prospects for Labour

Many thousands of socialists and progressives have hailed recent left breakthroughs in the Labour Party. Indeed, the success of the movement popularly identified with Tony Benn has been one of the few exciting features of a political landscape otherwise filled with gloom and defeat.

Yet that very success has masked fundamental weaknesses within Labour's 'new left' — weaknesses which have now given the Party's right an opening through which to go onto the offensive. Suddenly, all the advances since the late 1970s look rather precarious.

How has this happened and what must be done to regain the initiative?

First of all it is important to recognise that the comparatively recent swing to the left had its roots in the disenchantment with the performance of Labour in office, going right back to the 1960s. It was in reaction to the failures of the 1964-70 Wilson years that the Party began shifting leftwards, adopting in 1973 a programme that was probably the most radical in its history. Propelled by Party activists determined to have socialist policies for a change and by a trade union movement blooded on the anti-Tory militancy of the early 1970s, Labour came back into office in 1974 with the ruling class in retreat.

But the policy advances made whilst in opposition were soon blocked and there was the familiar tale of compromise and sell-out, ending with the 1979 election being fought on a centrist manifesto after relations with the unions had been soured by the winter confrontation over pay.

The cumulative effect of all this was to push Party members to make increasingly uncompromising demands. Already, the pressure for mandatory reselection had built up and now the left concentrated on pressing for accountability of the leadership. What amounted to a coalition between left constituency parties and trade unions still embittered by rigid pay restraint, carried the historic reforms on reselection and electing the leader. It was this combination of *political* disillusion in the constituencies and *economic* disillusion in the unions that enabled the left to achieve success.

The sheer breadth of support overcame bitter intransigence from the right, the tactical brilliance and hard work of the Campaign for Labour Party Democracy giving the necessary cutting edge.

In one sense these victories did have solid foundations in the rank and file, defined as constituency and union *activists*. Without their pressure on Party and union leaders the reforms could not have been won.

But in another sense the reforms were less firmly based. The 'real' rank and file of the labour movement had not necessarily been won to the left's cause. Even the extent of support amongst shop stewards and branch officials was exaggerated in the heady days following the 1979 and 1980 conferences.

What the Labour left had done was to exploit to the full the democratic machinery of the Party and to do so with relentless energy. Essential as this was — it is hard to see how else the reforms could have been won — the strategy was entirely within the tradition of British 'labourism'. That is to say, the left's campaign hardly engaged at all with wider class and group forces outside the official structures of the labour movement.

It was a characteristically inward-looking campaign. Even sympathetic outsiders could be forgiven for interpreting it as just another bureaucratic power battle amongst competing elites remote from ordinary workers and voters.

As a result the foundations of the left's advances were a great deal more fragile than many were prepared to admit. Just to rub home the point, the conference majorities for the reforms were very narrow and some of them came only after the right had been outwitted on the day by the left's greater tactical acumen. They were also produced by the swings of a few union block votes that could so easily have gone the other way.

The situation in the country

Moreover, the left may have been winning in the *Party* but right wing ideas were meanwhile winning in the *country*, the ideological lurch rightwards under Thatcherism being symptomatic of this.

Such is the nub of our present predicament and the reason why Labour's left could so easily be marginalised.

For instance, extravagant claims were made just a year or two back for the way the unions were swinging leftwards. That may have been true for a layer of union *activists*. But it was emphatically not true of ordinary union members who were demoralised by Thatcherism and remained ripe for plucking by right wing union leaders and now — as has happened over the register — by the Party establishment.

Even the Deputy Leader campaign — the focus for the left's activity in 1981 as the next stage on from winning the reforms — contained more salutary lessons than many were willing to acknowledge in the after-